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ABSTRACT

The purpose of the project was to determine what goals, content, and learning experiences in psychiatric-mental health nursing should be included in diploma and associate degree education for nursing in the light of present-day trends in nursing and psychiatric care. The report follows the sequence of the project: (1) selection of associate degree and diploma programs to participate in the project, (2) assessment of the current offerings in psychiatric-mental health nursing in the selected programs, (3) identification of goals and selection of content and learning experiences through the participation of a group of clinically competent psychiatric nurses as project consultants, and (4) testing and evaluating the resulting method and materials in the participating programs by instructors prepared through a workshop. The final section presents evaluations of the project by participating programs and project staff. Appended are: (1) questionnaires utilized in the project, (2) a listing of questions discussed with consultants from associate degree and diploma programs, (3) a listing of terminal expected competencies, (4) a listing of operational definitions, (5) a bibliography, and (6) progress reports. (JK)

ED034870

AN APPROACH TO THE TEACHING OF PSYCHIATRIC NURSING IN DIPLOMA AND ASSOCIATE DEGREE PROGRAMS:

FINAL REPORT ON THE PROJECT

Joan E. Walsh, Project Director and Principal Investigator
and
Cecelia Monat Taylor, Assistant Project Director and Consultant

This project was supported in part by training grant number 8230-05 from the National Institute of Mental Health, U. S. Public Health Service.

NATIONAL LEAGUE FOR NURSING
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Other Publications From the Project

Teaching Psychiatric Nursing in Diploma and Associate Degree Programs, by Joan E. Walsh. Nursing Outlook, June, 1967. (The section of the present report beginning on page 6 was adapted from this article.)

Expected Competencies as a Basis for Selecting Content in Psychiatric Nursing, by Joan E. Walsh and Cecelia A. Monat. Nursing Outlook, July, 1967.

Reprint of the two articles available from NLN. Publication No. 33-1275; $1.00.

An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: Workshop Report. New York, National League for Nursing, 1967. Publication No. 33-1288; $1.50.

Integrating Psychiatric – Mental Health Nursing Content in the Curriculum, by Joan Walsh and Cecelia Monat Taylor. Nursing Outlook, November, 1968. (This article was adapted from the section of the present report beginning on page 24.)

Reprint available from NLN. Publication No. 19-1346; 35 cents.

An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: A Method for Content Integration and Course Development in the Curriculum. New York, National League for Nursing, 1968. Publication No. 19-1336; $2.25.

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PREFACE

In July of 1963, the National League for Nursing was awarded a grant from the National Institute of Mental Health for a four-year demonstration project entitled "An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs." An additional grant for one year for the purpose of evaluation was received in 1967. At the time of the original grant, the administration of the project was under the Mental Health and Psychiatric Nursing Advisory Service of NLN. With the reorganization of the League, which was approved at the 1967 biennial convention, the Council on Psychiatric and Mental Health Nursing was automatically dissolved at the national level, and subsequently, the Advisory Service was discontinued as a separate unit. At that time, the administration of the project was placed under Research and Development.

The project was initiated through the Mental Health and Psychiatric Nursing Advisory Service and the former Department of Diploma and Associate Degree Programs. (In 1965, the Department of Associate Degree Programs was established at NLN headquarters as a separate unit.) Prior to proposing the project, the Advisory Service and the Department of Diploma and Associate Degree Programs had been receiving increasing numbers of requests from schools for consultation regarding various aspects of their courses in psychiatric nursing and for assistance in planning for integration of psychiatric-mental health nursing content throughout their curriculums. There was, as always, the problem of a shortage of prepared faculty in programs of both types. It was determined that the project would be concerned with the integration of psychiatric-mental health nursing content as well as with the course in psychiatric nursing.

Mary F. Liston was principal investigator of the project from its inception in 1963 to September, 1966, in her capacity as director of the Advisory Service and also as director of the Division of Nursing Education from 1965 to 1966. Joan E. Walsh served as project director from 1964 to 1966 and as both principal investigator and project director from September, 1966, to June, 1968, when the project was completed. Cecelia Monat Taylor was assistant director and consultant to the project from 1965 to 1968. M. Phyllis Hurteau held those positions from late 1963 through 1964.

An advisory committee to the project was appointed in 1964. The committee met annually to assist the staff with the development of the project. Mary M. Redmond, Acting Director of the School of Nursing at Catholic University of America, was consultant in the formation of the project and chairman of the advisory committee until her death in 1965. Since that time, Mrs. Lorene Fischer, Associate Professor of Nursing, Wayne State University, served in this capacity. The members of the committee were representative of graduate education in psychiatric nursing, of associate degree nursing education, of diploma school nursing education, and of departments of nursing in psychiatric hospitals. In addition, the project staff received considerable assistance from members of the NLN staff in the Department of Diploma Programs, the Department of Associate Degree Programs, and the Research and Development Unit and from the former Steering Committee of the Council on Psychiatric and Mental Health Nursing. Individuals who were very generous with their time and whose consultation was most helpful were Gertrud Ujhely, Margaret M. Wright, John V. Gorton, Wallace Mandell, and Harry W. Martin.

Special assistance was provided by groups of associate degree and diploma educators, psychiatric nursing educators, and psychiatric nursing service administrators in the development of the project method and materials. Several members of these groups also served as resource people during a workshop for faculty representatives of the participating programs.

Special thanks are extended to the directors and faculties of the participating programs, who worked diligently throughout the project. Without their interest and cooperation, the project could not have been accomplished.

On the following pages are listed the project staff and the educational programs and the persons to whom NLN is indebted for their contributions to the carrying out of the project.

--J.E.W. and C.M.T.

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INTRODUCTION

NEED FOR THE PROJECT

The National League for Nursing, since its inception in 1952, has been seriously concerned with the problem of education for psychiatric nursing. In 1953, the NLN Board of Directors stated that "the basic program of education for professional nursing should prepare nurses for beginning positions in the care of psychiatric patients just as it prepares them in the care of medical-surgical, obstetric, and pediatric patients."[1] This was the first official statement by a nursing organization relative to the responsibility of preservice nursing programs for preparing beginning first-level practitioners in psychiatric nursing.

In keeping with this interest and expressed philosophy, NLN has conducted a number of projects in the past, with generous assistance from the National Institute of Mental Health, on baccalaureate education in psychiatric nursing, on graduate education in psychiatric nursing, and on inservice education for professional nurses and psychiatric aides. Prior to the present project, the areas of diploma and associate degree nursing programs and their psychiatric nursing components had not been investigated.

The report of the Joint Commission on Mental Illness and Health, Action for Mental Health, indicated that while all the psychiatric disciplines had serious manpower shortages, nursing was in the most acute need. The report stated. "The mental health professions need to launch a national manpower recruitment and training program, expanding on and extending present efforts and seeking to stimulate the interest of American youth in mental health work as a career. This program should include all categories of mental health personnel. The program should emphasize not only professional training but also short courses and on-the-job training in the subprofessions and upgrading for partially trained persons."[2]

It was in keeping with the intent of the recommendation that this project was proposed. Nursing has a great potential of possible mental health manpower. However, in the past, this manpower has been largely an untapped reservoir for a diversity of reasons. Seventy-five percent, or 26,278, of the 35,125 nursing students graduated from schools of nursing in 1965-1966 were from 822 diploma nursing programs; in addition, 3,349 students were graduated from 218 associate degree programs.[3] These 29,627 graduates are a vast potential resource for psychiatric nursing.

An important factor underlying the recruitment problem in psychiatric nursing is concerned with the student's first introduction to the field during her basic program. Studies have shown that in diploma programs especially, this introduction may be entirely frustrating, even traumatic, to the student, since she is not provided with the expert guidance needed to develop satisfying, therapeutic relationships with patients. In addition, it might be expected that those who ultimately select psychiatric nursing as a career would have had a basic learning experience on which clinical expertness might be built through further education and experience. At the present time, nurses who elect to continue in psychiatric nursing have for the most part very inadequate grounding in the subject and require much supplementary assistance before they are ready for advanced study or for experiences that require an ability to relate helpfully to patients. Consideration must also be given to the fact that the graduate of the diploma school or associate degree program must complete the requirements for the baccalaureate degree in nursing before she is eligible for admission to a masters program of specialization in psychiatric nursing.

The woefully inadequate recruitment of nurses for the field of psychiatric nursing indicates an imperative need for critical review of what is currently being offered as the content and learning experiences in psychiatric nursing in preservice nursing programs. Much of the current offerings are traditionally oriented, are limited in depth and breadth of content, and lack emphasis on the dynamic aspects of psychiatric nursing. At the time the project was instituted, they were primarily offered as "affiliation type" experiences.

In a study of diploma students, Long found that "there was a very marked association between degree of satisfaction with and during the psychiatric affiliation and level of preference for psychiatric nursing as a future career at the end of the affiliation. This relationship was a very strong one, and clearly indicates that reactions to the psychiatric affiliation are of great importance with respect to psychiatric nursing and future career choice."[4] Albee suggested "that research is needed to determine whether changes in locus and program of the psychiatric affiliation, on an experimental basis, would result in increases in the number of student nurses recruited to the psychiatric field."[5]

The identification of content in psychiatric nursing is of tremendous importance. Changing methods and concepts of treatment of the psychiatric patient--including day-care centers, aftercare clinics, the follow-up care of discharged psychiatric patients and their families, new treatment programs in mental hospitals, the emphasis on prevention of mental and emotional disorders--are developments that have created the need for fundamental changes in course offerings in psychiatric nursing.

The hospital is no longer the focal point of psychiatric care. The community is very much involved in mental health and psychiatric activities. Nurses need to be involved in learning experiences that include the whole mental health continuum--promotion of mental health, prevention of mental disorders, treatment of the mentally ill, and rehabilitation. This type of involvement will lead to improved practice in all of nursing. In view of these factors, it is important to redefine the goals, content, and learning experiences for psychiatric nursing appropriate for diploma and associate degree nursing programs.

THE GOAL OF THE PROJECT

The goal of the project was to improve the teaching of psychiatric-mental health nursing in diploma and associate degree nursing programs through the development of goals and the selection of content and learning experiences appropriate to this level of education, in the belief that improvement of the teaching process would ultimately lead to better general nursing practice in all settings as well as increased recruitment of nurses for nursing care of the mentally ill.

THE PURPOSE OF THE PROJECT

The purpose of the project was to determine what goals, content, and learning experiences in psychiatric-mental health nursing should be included in diploma and associate degree education for nursing in the light of present-day trends in nursing and psychiatric care.

THE PROJECT PLAN

The project plan consisted of the following steps.

1. Appointment of an advisory committee to assist the staff with the study plan.
2. Selection of programs to participate in the project on the basis of established criteria, these programs to serve as testing centers.
3. Assessment of the current offerings in psychiatric-mental health nursing in these programs.
4. Identification of goals and selection of content and learning experiences in psychiatric-mental health nursing for diploma and associate degree programs.
   a. Selection of a group of clinically competent psychiatric nurses to serve as consultants in the development of methods and materials for the identification of goals and the selection of content and learning experiences in psychiatric-mental health nursing for diploma and associate degree nursing programs.
5. Testing and evaluation of the method and materials developed within the project through application in the participating programs.
   a. Preparation of instructors from the participating programs for utilization of the methods and materials through a workshop.
6. Development of guidelines, on the basis of the tested methods and materials, for the development of course offerings in psychiatric-mental health nursing in diploma and associate degree nursing programs.

SURVEY OF COURSES IN PSYCHIATRIC NURSING

Prior to the selection of programs to participate in the project and the development of the questionnaire to be sent to the participating programs, a survey was done to determine present patterns in the teaching of psychiatric nursing in the two types of programs. Course outlines were obtained from ten programs of each type, representing sixteen states in different regions. The outlines were analyzed in terms of philosophy, objectives, time allotment, teaching methods, content, methods of evaluation, and credits allotted. This information was helpful in demonstrating similarities and differences between the two types of programs.

References

1. "Board Action on Psychiatric Aide Education." Nurs. Outlook 1:67, Mar. 1953.
2. Joint Commission on Mental Illness and Health. Action for Mental Health. New York, Basic Books, 1961, p. 252.
3. State-Approved Schools of Nursing--R.N. New York, National League for Nursing, 1967, p. 106.
4. Ernest S. Long. Determinants of Career Choice in Psychiatric Nursing. Cleveland, Mental Health Manpower Office, 1958, p. 170.
5. George W. Albee. Mental Health Manpower Trends. New York, Basic Books, 1959.

SELECTION OF PROGRAMS TO PARTICIPATE IN THE PROJECT

Fifty-four programs across the country were selected as the preliminary sample. Of the 54, 23 were associate degree programs and 31 were diploma programs. Letters of invitation to participate in the project were sent to the programs in November, 1964, together with a short questionnaire soliciting information that would be needed in order to make the final selection. A second attachment consisted of a list of the principal criteria for selection and an outline of the plan for school participation for the agreement of participating programs. (See Appendix A.)

On the basis of the responses, the final sample of 16 programs, 8 diploma and 8 associate degree, and 6 alternates were chosen in accordance with the criteria for selection developed by the staff and the advisory committee. These criteria were as follows.

CRITERIA FOR SELECTION OF THE PROJECT SCHOOLS

Associate Degree Programs	Diploma Schools
The chief administrative officer of the school is willing to give official authorization to utilize faculty, students, and facilities that would be involved in the project according to its design.	The chief administrative officer of the school is willing to give official authorization to utilize faculty, students, and facilities that would be involved in the project according to its design.
The total faculty of the nursing program is willing to participate in the project, since it is aimed at total curriculum.	The total faculty of the school is willing to participate in the project, since it is aimed at total curriculum.
The school will permit the project staff to visit the nursing faculty in a consultant capacity when appropriate during the project.	The school will permit the project staff to visit the faculty in a consultant capacity when appropriate during the project.
The contract with the cooperating agency insures that the faculty have full control of the students' learning activities.	The home school faculty or the faculty of the affiliating agency have control of the students' learning activities.
The faculty responsible for the course in psychiatric nursing have graduate preparation in psychiatric nursing or a minimum of a bachelors degree with psychiatric nursing experience.	The faculty responsible for the course in psychiatric nursing have graduate preparation in psychiatric nursing or a minimum of a bachelors degree with psychiatric nursing experience.
The schools as a group utilize cooperating agencies that are typical of various structures or patterns of psychiatric care--*i.e.*, psychiatric unit in general hospital, V.A. hospital, state hospital, et cetera.	The schools as a group utilize cooperating agencies that are typical of various structures or patterns of psychiatric care--*i.e.*, psychiatric unit in general hospital, V.A. hospital, state hospital, et cetera.

Associate Degree Programs	Diploma Schools
The instructors will be available for a workshop experience prior to utilization of the guidelines and resource materials developed in the project.	The instructors will be available for a workshop experience prior to utilization of the guidelines and resource materials developed in the project.
The schools are interested in an active follow-up study of their graduates following completion of the program.	The schools are interested in an active follow-up study of their graduates following completion of the program.
At least one class of students has graduated from the program as of 1964.	
The clinical facility has a partial amount or the gamut of newly recommended services available for clinical experience (*e.g.*, day-care programs, follow-up programs, et cetera).	The clinical facility has a partial amount or the gamut of newly recommended services available for clinical experience (*e.g.*, day-care programs, follow-up programs, et cetera).
The schools as a group are reasonably close to each other in clusters to facilitate travel for the project staff in the particular region.	The schools as a group are reasonably close to each other in clusters to facilitate travel for the project staff in the particular region.
The course in psychiatric nursing is not more than 8 weeks but not less than 6 weeks in length.	The course in psychiatric nursing is not more than 12 weeks but not less than 8 weeks in length.
The schools as a group are representative of state, tax-supported, and privately operated organizations or agencies.	The schools as a group are representative of state, tax-supported, and privately operated organizations or agencies.
The school is a member of the NLN Council of Member Agencies of the Department of Diploma and Associate Degree Programs or has applied for membership.	The school is accredited by NLN and is a member of the NLN Council of Member Agencies of the Department of Diploma and Associate Degree Programs.
The nursing program is under the control of a junior or community college.	

ASSESSMENT OF THE PARTICIPATING PROGRAMS' CURRENT OFFERINGS IN PSYCHIATRIC-MENTAL HEALTH NURSING (1964-65)

To gather information about the participating programs relative to philosophy and objectives of the program, curriculum design, objectives of and content in the psychosocial sciences and clinical nursing courses, a more extensive questionnaire was constructed and sent to the 16 programs and 6 alternates. (See Appendix A for questionnaire.) The course or unit in psychiatric nursing or nursing in mental illness was explored in detail as to objectives, content, teaching methods, plan for clinical experience, criteria for selection of cooperating agency, and evaluation methods. Participating programs were visited by members of the project staff to elicit further data that could not be ascertained by means of the questionnaire.

Twelve states were represented in the programs chosen to participate in the project, three in each NLN region. Responses to the questionnaire revealed that state board requirements for the course in psychiatric nursing varied. For the diploma programs, three states had regulations for the number of class hours and five had regulations for the number of days of clinical experience. One had educational requirements for instructors. In respect to associate degree programs, two states had requirements for the number of credit hours and one required approval of the course plan. For both types of programs, most states required approval of clinical agencies.

ASSOCIATE DEGREE PROGRAMS

Of the eight associate degree programs participating in the project, three were privately controlled and five were under public administration. Some of these programs were two calendar years in length, some were two academic years, and some were two academic years and one summer.

At the time the questionnaires were returned (spring, 1965), 17 of the 184 graduates from the class of 1964 were employed in psychiatric nursing. Eleven were employed in psychiatric hospitals, 6 in psychiatric units of general hospitals. Twenty from the 1963 class and 9 from the 1962 class were employed in psychiatric nursing.

The educational preparation of the faculty teaching psychiatric nursing or nursing in mental illness was comparable to that of faculty teaching in other clinical courses. Eleven had masters degrees in psychiatric nursing, two had masters degrees in different clinical areas, two held a baccalaureate degree but were not in charge of the course. The faculty-student ratio in the laboratory ranged from 1 to 4 to 1 to 15. Three programs used a psychiatrist as the major lecturer.

Some statements in the philosophies of the programs were similar. Most said that the program in nursing is operated within the framework of the philosophy of the college and that this underlies and shapes planning for the nursing program. Another statement occurring frequently was that the responsibility of the college and the nursing program is to meet the needs of the community and to educate the student to assume her role as

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This section was adapted from "Teaching Psychiatric Nursing in Diploma and Associate Degree Programs," by Joan E. Walsh. Nursing Outlook 15:30-35, June 1967.

a citizen. In all programs there were statements of beliefs about education, learning, nursing, and nursing education, but there were considerable differences on these points.

The college objectives included emphasis on the student's growth, self-direction, and responsibilities as a citizen and as a professional person. Among the program or department objectives was the statement that there was a balance between general education and nursing education courses. Other objectives were to prepare the student to: develop the ability to plan, administer, and evaluate nursing care, utilizing basic principles as they applied to nursing problems presented by patients of various ages; function with intellectual and technical competency under supervision in giving nursing care to a group of patients in a hospital; learn principles of nursing care; provide nursing care to all categories of patients, including the mentally ill. The ability to communicate with the patient, his family, and all members of the health team was an objective in most programs. One associate degree program had objectives for the different levels in the curriculum.

Mental health aspects were an integral part of the program objectives. Some examples of the aspects included were: interpersonal relationships and communication skills, emotional-social aspects of general patient care, and student self-understanding and growth. There was more emphasis on the use of a variety of community agencies in the objectives of the associate degree programs than in those of the diploma schools.

There was considerable variation in the course requirements in the psychosocial sciences. Most required one course each in psychology and sociology. Others required a course in one or the other. Half required a course in child psychology. The number of credit hours required ranged from 3 to 13. The total number of credit hours for the program ranged from 65 to 79, of which 24 to 44 were in nursing. The hours of instruction and laboratory varied considerably for the nursing courses.

Three of the programs had a course in team nursing, while the remainder incorporated this content in other courses. Half of the programs had a course in maternal and child health nursing, focused on the normal, with nursing care of the ill child included in the course in nursing in physical and mental illness. The other half had separate courses in nursing of children and maternity nursing. These four programs also had a separate course in growth and development,or child psychology.

Some of the programs taught maternal and child health nursing before psychiatric nursing. Two had this content area following nursing in mental illness, and one alternated the two. Three of the programs offered psychiatric nursing as a unit in the course in nursing in physical and mental illness, rather than as a separate course.

Prerequisites for the course in nursing care of the mentally ill were courses in psychology, sociology, child development, fundamentals of nursing, maternal and child health nursing, and nursing in physical illness. Inasmuch as the faculties believed that content should proceed from the normal to the abnormal and from the simple to the complex, content prerequisites were: interpersonal relationships, communication skills or interviewing skills, the meaning of behavior, anxiety and the defense mechanisms, patient needs and feelings, growth and development, self-concept, roles of the nurse, the students' own reactions and expectations, family reactions, psychosomatic disorders, and community resources. Most of the departments had identified psychiatric-mental health nursing content in all clinical nursing courses.

Reinforcement of content and skills learned in psychiatric nursing was accomplished in the following ways: the instructor in psychiatric nursing assisted in the course in nursing in physical illness and served in a team relationship or as a resource person for the other clinical courses; the other instructors knew the psychiatric nursing content;

the instructor was involved in curriculum planning; there was an ongoing plan for the integration of psychiatric-mental health nursing concepts in the curriculum; the reinforcement of content and skills from psychiatric nursing showed in the objectives of the remaining courses; nursing care was individualized and was included in the patient care plan; patient needs were identified through problem-solving; mental health principles were brought out in nursing conferences, and it was the student's responsibility to apply these principles.

In regard to the placement of the course or unit in psychiatric nursing or nursing care of the mentally ill, only one program placed it in the first year--the second semester. Four offered it in the summer, two in the first semester of the second year, and one in the second semester of the second year. The length of the course varied from 3 (concentrated) to 11 weeks. The total number of class hours ranged from 15 to 45; the total number of laboratory hours, 60 to 165, or the total number of laboratory days, 12 to 22. The total number of hours for the entire course varied from 90 to 209. Semester credits for the course ranged from 3 to 8.

The programs were equally divided in general focus of the course, with half stating that they prepared the graduate for beginning first-level practice in nursing care of the mentally ill, while the others said that the objective of the course was primarily to broaden and deepen the students' interpersonal skills and knowledge of human behavior.

The objectives for the course or unit were related to knowledge of psychiatric theories, diagnostic categories, and treatment methods; understanding patient behavior; establishing relationships; improving communication skills; knowledge of the principles of psychiatric nursing; applying nursing skills in the psychiatric setting; functioning in the roles of the psychiatric nurse; student awareness of her own behavior and her personal growth; use of problem-solving; functioning in patient groups; functioning as a member of the nursing team and the interdisciplinary team; understanding and promoting the therapeutic milieu; knowledge of community agencies and their role in prevention of mental illness and rehabilitation of the mentally ill.

Three of these programs had stated expected competencies in behavioral terms for the course. These competencies can be classified under the following subjects: observation and recording, communication skills, nurse-patient relationships, the nurse's role in the therapeutic milieu, group dynamics, and problem-solving.

The problem-solving approach, focused on patient care plans, was used frequently. The direction of the course was on patient behavior patterns and nursing intervention. Process recordings were used as a teaching tool in some cases but were not always followed by individual conferences. The associate degree programs used pre- and postconferences more often than the diploma schools. Preconferences were used for daily planning, and postconferences were used to discuss the students' feelings and to plan for patient care. The course outlines did not always indicate that content and learning experiences were concurrent.

Mental illness as a community problem, agencies concerned with prevention of mental illness, and care and follow-up of the mentally ill were included as part of the content in most of the programs. The associate degree programs stressed the role of the general hospital nurse in primary prevention of mental illness more often than did the diploma programs. About one-half of the programs included the activities of the public health nurse related to the promotion of mental health.

In regard to students working with groups of patients, one-half of the programs were not concerned with this in any way except for student participation in social-recreational patient groups. In some of the programs, students planned diversion for patient groups.

Some observed group therapy sessions or remotivation activities; others had students observe a ward government meeting. A few of the programs had the students study their own group interactions, but in most cases, there was no formal content on group dynamics.

The programs used a variety of agencies for their clinical laboratory in psychiatric nursing. Two used a state hospital exclusively; two used private psychiatric hospitals; one used a county psychiatric hospital; two used both a state hospital and a general hospital psychiatric unit; and one used a state hospital and a general hospital medical-surgical unit. Students stayed on one unit when they were not involved in two different hospitals. Field trips were made to state hospitals when such hospitals were not used for learning experiences. The other most frequent supplementary field trips were to clinics for alcoholics, schools for the mentally retarded, and psychiatric day hospitals. The clinical laboratories were selected on the basis that they would provide the experiences necessary to meet the course objectives. Other factors considered were proximity, reputation of the hospital, and facilities offered, i.e., treatment methods, quality of care, variety of patients.

In some cases, students either did not have the opportunity or did not choose to collaborate with members of other disciplines in relation to the care of their patients. Some did not discuss the functions of the other disciplines. A few had experience in team nursing in the psychiatric setting. Three agencies were staffed by auxiliary personnel only. Not all agencies had nursing care plans for the patients and not all had nurses' notes. In some agencies, students were not allowed to chart on the nurses' notes. The nursing departments of some of the hospitals had no philosophy or objectives. The evaluation methods used by nursing service were quite varied.

Evaluation methods often used for students in the course or unit in psychiatric nursing or nursing care of the mentally ill were terminal behaviors and critical requirements. Diaries or process recordings followed by individual conferences were also used frequently. Grading systems were: no mark for laboratory; separate laboratory and class grades; "satisfactory" or "unsatisfactory" for the course; "must pass laboratory"; or were the same as for other courses.

DIPLOMA PROGRAMS

Of the eight diploma programs selected to participate in the study, five were under private control and three were in public institutions. Two of the programs used federal hospitals in an affiliation arrangement for their course in psychiatric nursing. Two used a state psychiatric hospital as a clinical laboratory and had their own instructor; four used the psychiatric units in their home hospitals with their own instructor. Field trips were taken to state hospitals when such hospitals were not used. Other field trips were the same as for the associate degree programs. The length of the total program varied from 27 to 36 months, with considerable variation in the hours for class and clinical instruction for the different clinical courses.

Two had an instructor whose major responsibility was integration of mental health concepts. Four additional programs had an ongoing plan for integration of mental health concepts in the curriculum. The educational background of the instructors in psychiatric nursing varied: 15 had a masters degree in psychiatric nursing; 8, a baccalaureate degree; and 5 were diploma graduates. More instructors in psychiatric nursing had a masters degree in their clinical area than did faculty in other clinical areas. The faculty-student ratio in the clinical laboratory ranged between 1 to 4 and 1 to 15.

Out of a total of 321 students graduating from these programs in 1964, 21 were known to be working in psychiatric nursing at the time of this survey (spring, 1965). Also working in this field were 22 from the 1963 class, 11 from the 1962 and 1961 classes, and 13 from the 1960 class.

In regard to philosophy of the programs, there was considerable agreement among schools in their statements on education, nursing, nursing education, and learning. The differences were in what the graduate was prepared to do. Most said that the faculty was responsible for planning, providing, and implementing learning experiences.

Program objectives that pertained to mental health aspects were concerned with preparing students to provide nursing care to all categories of patients, including the mentally ill. One frequently mentioned objective was that students learn the principles of nursing care. In most schools, emphasis was placed on students' ability to communicate with patients, families, and all members of the health team. Objectives related to the student herself, her growth, self-direction, and responsibilities as a citizen and as a professional person, were comparable to some of the college objectives of associate degree programs.

All diploma programs had curriculum objectives and most had level objectives. Included were mental health aspects as an integral part of both types of objectives. Examples of mental health aspects were: interpersonal relationships, communication skills, emotional-social aspects of general nursing care, and student self-understanding and growth. Seven of the participating schools had identified the mental health content in clinical courses other than psychiatric nursing.

All of the programs required at least one course in psychology and one in sociology. In most cases, students received college credit for these courses. Three had a separate course in growth and development and three had a course in maternal and child health nursing focused on the normal. Most had a course in team nursing, and four offered a course in community nursing. The curriculums, in general, were quite varied.

There was considerable variation in the placement and length of the course in psychiatric nursing. In most instances, it was offered in the second half of the second year or the first half of the third year. In all but one school, the course was completed at least half a year before the end of the program. Only two programs gave psychiatric nursing prior to pediatric nursing. In general, all clinical courses were longer than those in the associate degree programs. In several cases, psychiatric nursing alternated with other courses. The course in psychiatric nursing varied in length from 6 to 13 weeks. The total hours of instruction were from 208 to 504, with 40 to 85 for class, and 143 to 360 for clinical laboratory. The laboratory hours were from 22 to 33 per week.

Student preparation for the course consisted of an orientation, course prerequisites, or preceding content. The two schools with affiliation programs had a preaffiliation orientation. The cooperating agencies were near the home school and maintained a close working relationship with the home school. The two schools that used a cooperating agency but had their own instructor also had a prior orientation to the course and to the hospital.

Course prerequisites listed were: psychology, sociology, growth and development, fundamentals of nursing, and medical-surgical nursing. Essential content preceding the course came under the following major headings: emotional-social development, family relationships, mental mechanisms and behavior, communications, patient feelings, student feelings, roles of the nurse, and community resources.

One question concerned reinforcement of learnings in psychiatric nursing in succeeding clinical courses. Responses were that the faculty was familiar with the content in psychiatric nursing, that the instructor in psychiatric nursing was involved in curriculum planning, that the objectives for the succeeding courses provided for building on the psychiatric nursing content, and that it was the students' responsibility to utilize their previous learnings in patient care.

About half of the schools stated that the purpose of the course was to prepare the students for beginning positions in psychiatric nursing. The other half stated that the purpose was primarily to broaden and deepen interpersonal skills and knowledge of human behavior. About half of the programs had written expected competencies for the course in psychiatric nursing. These came under the headings of problem-solving, interpersonal relationships, communications, reporting and recording, working with others, and student awareness of own behavior.

Course objectives were most often formulated by the instructor responsible for the course. These were broken down into the following categories: knowledge of psychiatric theory, diagnostic categories, and treatment methods; principles of psychiatric nursing and functions of the psychiatric nurse, including her use of self and self-understanding; her role in prevention of mental illness and rehabilitation of the psychiatric patient; promotion of the therapeutic milieu; functioning on the interdisciplinary team.

Course outlines indicated that content and learning experiences were concurrent. The course was approached from the standpoint of the nurse-patient relationship. Process recordings were used but were not always followed by individual conferences. Nursing care plans were written by students in some schools. Most schools required case studies. Three schools used psychiatrists as major lecturers. These were schools that had their own instructor. Psychiatrists also held 6 to 12 hours of conferences with students in several schools.

One-half of the schools included in their course content the activities of the public health nurse related to promotion of mental health, and the consideration of mental illness from the standpoint of a community problem. Field trips were taken by some schools to agencies concerned with prevention and follow-up. Four of the schools included the group interaction process in their course content. In one instance, the students led patient discussion groups. One-half of the schools were not concerned with patient groups in any way other than student participation in patient social-recreational activities. Otherwise, content and experience in patient groups were the same as those in associate degree programs.

In the diploma programs, students often had experience in team nursing in their clinical laboratory in psychiatric nursing. Some did not or could not collaborate with other disciplines in relation to care of their selected patients. Some did not include functions of other disciplines in their course content.

The cooperating agency was selected on the basis of proximity or its reputation and facilities--i.e., its treatment methods, quality of care, and variety of patients. The qualifications of the agency faculty were important when the school used the agency for an affiliation. The philosophy, objectives, and evaluation methods of the nursing service department were quite varied. In the case of schools using psychiatric units in their home hospitals, the views, goals, and methods were usually the same as for the total hospital. Not all psychiatric units and agencies had nursing care plans for patients. In some cases, students could not chart on the nurses' notes, and not all agencies had nurses' notes.

Most students had experience with patients hospitalized on a short-term basis. In five schools, the students stayed on one unit during the course (8 to 9 weeks). In another five, they rotated to a second unit (12 to 13 weeks). In one, they rotated through four units in 8 weeks; in another, they remained on one unit or rotated to a second unit (6 weeks). One-half of the schools required the students to have evening experience.

Evaluation methods used were similar to those in the associate degree programs. Student self-evaluations, performance ratings, and the NLN achievement test were used more often by the diploma programs. Ratings by nurses in the cooperating agencies were included in some diploma programs. Grading systems for the course were similar to those of the associate degree programs for the most part, but grades were sometimes determined on the basis of percentages.

SPECIFIC CONTENT

One of the questions on the questionnaire concerned the placement of certain content in the curriculum. Because of the great variety in the answers, the responses of both types of programs are reported together.

As stated previously, some of the programs had a separate course in growth and development. Those that did not have a separate course included such content in other clinical areas of the curriculum--*i.e.*, fundamentals of nursing, maternal and child health nursing, and nursing in physical and mental illness. In most cases, the content in growth and development extended through senescence. If not, the content on the adult and the aged was added to the content on physical illness. It appeared that there was much overlapping and duplication in this content area--*e.g.*, the content was taught or repeated in the courses in psychology, obstetric nursing, pediatric nursing, and psychiatric nursing even when there was a separate course in growth and development.

The content relative to nursing care of the mentally retarded was not included in some programs. When it was included, it was most often placed in maternal and child health nursing. Sometimes, it was repeated in psychiatric nursing. Most programs stated that they did not consider this content area separately, but rather considered it as a part of general nursing knowledge and care.

In regard to nondirective interviewing techniques or communication skills, some programs did not include this content in psychiatric nursing. Otherwise, it was introduced in fundamentals of nursing and continued in all clinical courses. Sometimes, it was introduced in psychiatric nursing or in a separate course on communications or interviewing skills.

There was much duplication and overlapping in the presentation of the content on anxiety and the defense mechanisms because of repetition of the content in different courses. Although it might have been introduced in psychology, it was reintroduced in fundamentals of nursing and psychiatric nursing even though application of these concepts was made in the nursing courses.

Content on group process was not included in some programs. Otherwise, the participating programs reported that it was included in courses in psychology, sociology, communications, fundamentals of nursing, psychiatric nursing, and team nursing.

Interdisciplinary team relationships was not included in the course in psychiatric nursing in some programs. Otherwise, it was a part of all clinical courses or was introduced in the course in team nursing.

Problem-solving and patient care plans were an inherent part of all clinical courses except psychiatric nursing in some cases.

Understanding patient behavior and supportive nurse-patient relationships were a part of all clinical courses or were included in the course in psychiatric nursing only. Sometimes, this content was included in some clinical courses but not in others.

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IDENTIFICATION OF GOALS AND SELECTION OF CONTENT AND LEARNING EXPERIENCES IN THE TEACHING OF PSYCHIATRIC-MENTAL HEALTH NURSING

DEVELOPMENT OF METHOD AND MATERIALS (1965-66)

Trends, Assumptions, and Definitions

Major trends in both nursing education and the care of the mentally ill were identified and underlying major assumptions and definitions of key words and phrases were developed in order to give direction to the methods and materials to be developed within the project.

The major trends in both nursing education and the care of the mentally ill that were identified were as follows.

1. Two levels of nursing practice as delineated in the ANA position paper on educational preparation for nurse practitioners.[1]
2. Integration of psychiatric-mental health nursing content throughout the curriculums of basic programs.
3. The role of the nurse in:
    a. The community mental health center.
    b. The therapeutic community as a treatment modality in psychiatric hospitals.
    c. Working with groups of patients as well as individual patients.
    d. Working with the nursing and interdisciplinary teams.

These trends provided a framework for determining the major underlying assumptions, which in turn gave direction for the subsequent development of the expected competencies and selection of appropriate content. Although there are many ways of looking at any one issue, these assumptions were made in order to facilitate a logical and consistent approach to further progression of content development.

Following are the major underlying assumptions that were developed, together with the definitions or explanations clarifying key words or phrases.* In view of generally accepted principles of education and the trends referred to above, these assumptions were believed to be applicable and valid for the purposes of the project.

1. Technical-level education in nursing prepares the graduate for beginning first-level practice in nursing care of patients with major health problems.

    Technical Occupation: A vocation requiring skillful application of a high degree of specialized knowledge together with a broad understanding of operational procedures; involving the frequent application of personal judgment; usually dealing with a variety of situations; and often requiring the supervision of others. It offers the opportunity for the worker to develop an ever increasing personal control over the application of his knowledge to his work and usually requires fewer motor skills than a trade or a skilled occupation and less generalized knowledge than a profession.

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*See Appendix F for glossary of all project definitions with documentation.

Beginning First-Level Practitioner: For purposes of this study, the term first-level practitioner designates a nurse who administers direct nursing care; i.e., performs intermediate nursing functions requiring skill and some judgment, in the presence or at the bedside of the patient who is under the care of a physician. She is a contributing member of the nursing team and works under the supervision of a nurse with broad professional preparation. She assumes some responsibility for the direction and supervision of those ancillary personnel who are members of the same team.

A beginning first-level practitioner is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience in nursing after graduation.

2. Psychiatric-mental health nursing content is part of all nursing content.

   Psychiatric-Mental Health Nursing Content: For purposes of this study, psychiatric-mental health nursing content is considered to be the knowledges that are related to the understanding of individual and group behavior. These knowledges are based on the psychosocial sciences, the biophysical sciences, and psychiatry. When applied in the practice of nursing, these knowledges are manifested in the ability to engage in nurse-patient interactions, nursing interventions, and the nurse-patient relationships, on both an individual and small-group basis. Inextricably involved in all of these abilities are communication and/or interviewing skills, skills in environmental modification, and appropriate attitudes in giving nursing care to all patients; i.e., both the physically and the mentally ill. Therefore, psychiatric-mental health nursing content is part of all nursing content.
3. Psychiatric-mental health nursing content in the curriculum proceeds from the normal to the abnormal and from the simple to the complex.
4. Content from the psychosocial sciences forms a base for psychiatric-mental health nursing content.
5. A course or unit in nursing care of the mentally ill is included in the curriculum and should be considered and managed in the same way as the other clinical courses. /Other content is determined by competencies, and competencies are determined in part by practice--therefore the definition that follows is concerned with the practice of nursing care of the mentally ill on the technical level./

   Beginning First-Level Practitioner in Nursing Care of the Mentally Ill: For purposes of this study, the term first-level practitioner in nursing care of the mentally ill designates a nurse who administers direct supportive nursing care to the mentally ill patient on a one-to-one or small-group basis. Direct supportive nursing care is rendered in the daily living situation in which the nurse and patient find themselves and is consistent with the overall treatment goal for the patient determined by the interdisciplinary team. The nurse focuses on strengthening the patient's areas of health and deals only with those thoughts and feelings that the patient brings up and with his behavior. Her nursing care is purposeful and planned, and although it may take many forms, it is based on her knowledges, skills, abilities, attitudes, and appreciations about the behavioral manifestations of the major forms of mental illness. Her primary therapeutic tool in her interactions with patients is "use of self."

In all her activities, the first-level practitioner in nursing care of the mentally ill functions under the supervision of a nurse with broad professional preparation in nursing or a professional psychiatric nurse. She is a contributing member of the nursing team and also functions as such on the interdisciplinary team as it establishes and implements total treatment plans for the patient.

A beginning first-level practitioner in nursing care of the mentally ill is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience after graduation in nursing care of the mentally ill.

Rationale Underlying the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs

On the basis of the trends, assumptions, and definitions, a general outline of beliefs relating to teaching psychiatric nursing in diploma and associate degree programs was developed by the staff. The purpose of this material was to suggest a general approach for faculty to use in planning for integration of psychiatric-mental health nursing content in their curriculums and in planning the course or unit in nursing care of the mentally ill. This material was also to be used by the staff as a guide for the development of the methods and materials to be used within the project, i.e., the development of objectives and the selection of content. These beliefs were reviewed by the Advisory Committee to the project and the Steering Committee of the Council on Psychiatric and Mental Health Nursing.

Two consultants were utilized by the project staff. One, an expert in nursing care of the mentally retarded, discussed content in this area appropriate for inclusion in technical-level nursing education. The second consultant, a director of a graduate program in psychiatric nursing, discussed organization of content.

The general outline of beliefs was sent to each director of the participating programs with the request that the total nursing faculty review and react to the statements, so they would be informed of the direction the project was taking and have an opportunity to express any disagreements with the beliefs in general and in terms of the philosophy of their type of program and to make suggestions for changes.

Meetings of Consultants

The next step in the development of the methods and materials was to seek consultation from faculty representing the different clinical areas from the two types of programs.

A two-day meeting was held with representative faculty members from diploma programs in different parts of the country who were responsible for teaching fundamentals of nursing, medical-surgical nursing, nursing of children, maternity nursing, and psychiatric nursing.

At this meeting, the trends, assumptions, definitions, and beliefs identified or developed within the project were discussed and suggestions were solicited. The consultants' views of integration in general were discussed, and expected competencies and critical incidents relating to psychiatric-mental health nursing were suggested. Broad areas of related content for integration and teaching methods were considered, as well as specific questions relating to the course in psychiatric nursing.

A separate two-day meeting was held with representative faculty members from associate degree nursing programs in different parts of the country who were responsible for teaching fundamentals of nursing, nursing in physical illness, maternal and child health nursing, and nursing care of the mentally ill. The same topics were discussed, and expected competencies and critical incidents were suggested. (For the specific questions discussed with the two groups, see Appendix C.)

After this meeting, and on the basis of the suggestions made by these groups, by the participating programs, and by the advisory and steering committees, the beliefs relating to the teaching of psychiatric-mental health nursing and the definitions were expanded into an educational orientation and an occupational orientation, or philosophy. On the basis of these orientations, expected competencies were stated relative to the general practice of nursing, the nurse-patient relationship, communication skills, working with groups of patients and functioning on the nursing and interdisciplinary teams, the therapeutic environment, and community aspects. Definitions of terms continued to be developed as needed.

Beginning plans were made for the organization of content within a conceptual framework on the basis of a theoretical orientation.

Meetings of Psychiatric Nursing Consultants

In accordance with the project plan, two one-week meetings were held in a university setting with a group of psychiatric nurses representing different levels of nursing education and types of settings for psychiatric care. Representatives were from graduate, baccalaureate, associate degree, and diploma educational programs and from a community mental health center and a psychiatric hospital. The purpose of these meetings was the development of methods and materials for the identification of goals and the selection of content and learning experiences in psychiatric-mental health nursing for technical-level nursing education programs.

At the first meeting, the educational, occupational, and theoretical orientations were reviewed and discussed, and suggestions were made. The expected competencies and related definitions were reviewed and revised. The general plan for organization of content was also considered. The staff was charged with developing suggestions of content, learning experiences, and evaluation methods flowing from the expected competencies within a conceptual framework and the organizational plan.

In carrying out the charge, worksheets were developed that showed the content divided into three categories: (1) knowledges, (2) skills and abilities, and (3) attitudes and appreciations, in the broad areas of individual behavior, communications, and environmental influences. Learning experiences and teaching and evaluation methods were planned concurrently. Further, the content, learning experiences, et cetera, were divided into those that precede the course or unit in nursing care of the mentally ill, those that are included in the course or unit in nursing care of the mentally ill, and those that follow the course or unit in nursing care of the mentally ill.

The organization plan for the development of content for integration developed by the staff follows.

I. Philosophy.

   A. Occupational orientation.

      1. Nursing.
      2. Technical-level nursing.
      3. Psychiatric nursing.
      4. Nursing care of the mentally ill.

   B. Educational orientation.

      1. Nursing education.
      2. Education for technical-level nursing.
      3. Education for nursing care of the mentally ill.

   C. Theoretical orientation.

      1. Man in health and in illness.
      2. Mental health and mental illness.

   D. Conceptual framework (from the theoretical orientation).

      1. Man in relation to himself.
      2. Man in relation to others.
      3. Man in relation to the nonhuman elements with which he lives; i.e., the environment.

II. Content and learning experiences.

   A. Terminal expected competencies.

      1. General practice of nursing.
      2. Nurse-patient relationship.
      3. Working with groups.
      4. Therapeutic environment.

   B. Threads of content.

      1. Dynamics of individual behavior.
      2. Dynamics of communications.
      3. Dynamics of nonhuman environmental influences.

   C. Content organization.

      1. Knowledges.
      2. Skills and abilities.
      3. Attitudes and appreciations.

   D. Learning experiences.

      1. Nurse-patient relationship.
      2. Working with groups.
         a. Patients.
         b. Interdisciplinary team.
         c. Nursing team.

E. Teaching tools and methods.

1. Nursing care plan.
2. Interaction notes and process recordings.

F. Evaluation methods.

1. Critical incidents.

III. Curriculum organization for integration of content, learning experiences, etc.

A. Preceding the course or unit in nursing care of the mentally ill.

B. Included in the course or unit in nursing care of the mentally ill.

C. Following the course or unit in nursing care of the mentally ill.

At the second meeting with the psychiatric nursing consultants, the expected competencies and definitions were further refined. The content, learning experiences, and teaching and evaluation methods as organized were discussed in detail, revised, and added to. Suggestions were made for guidelines for the schools and for implementation by the participating programs of the method of planning for integration, which had grown out of the orientations and the discussions of the materials. Suggestions of activities for the workshop for faculty from participating programs were also given.

Following are the steps in the method of planning for integration.

1. Consider the philosophy (man, nursing, and nursing education) and the overall objectives of the program.

2. Write terminal expected competencies for general nursing that include or indicate the emotional-social aspects of patient care. (Curriculum objectives.)

3. Some aspects of this that could be further spelled out as terminal expected competencies are:
    a. Nurse-patient relationship.
    b. Working with groups.
    c. Activities in relation to the therapeutic environment (in general).

4. Write level objectives in behavioral terms, and organize the level objectives so as to show progression by depth and sequence if necessary.

5. Using this organization, state course objectives in behavioral terms.

6. On the basis of the course objectives, plan for content within each level. State content as knowledges, skills and abilities, and appreciations. The content should show progression in depth and sequence.
    a. Include content from the behavioral sciences in Level 1.
    b. Plan for content in nursing care of the mentally ill.
    c. Show how the content in nursing care of the mentally ill builds on preceding content and how subsequent content builds on it.

7. An over-all conceptual framework for organizing content within each course might be:
    a. The dynamics of individual behavior.
    b. The dynamics of communication, including the nurse-patient relationship and the group process.
    c. The dynamics of environmental influences; e.g., physical, personal, and social aspects of the hospital and the community.

8. Plan for learning experiences and evaluation methods concurrently.

9. In all, faculty need to agree on their definitions of terms being used.

After refinement and revision on the basis of the outcomes of these meetings, all of the materials were reviewed by the advisory committee to the project.

The orientations, expected competencies, and content organization were further discussed on separate occasions with a consultant who was a clinical psychologist and a consultant who was a social scientist. Their suggestions were also incorporated or taken into consideration.

EVALUATION OF MATERIALS BY THE PARTICIPATING PROGRAMS

During the third phase of the project when the participating programs were serving as testing centers for the method and materials developed within the project, the faculties were sent a set of questions eliciting their opinions about the revised expected competencies and related definitions. (See Appendix D.) They had previously been sent these materials for their use as resource materials while developing their own as part of their implementation of the project method of planning for integration of psychiatric-mental health content throughout the curriculum and for the course or unit in nursing care of the mentally ill.

In addition to making suggestions, faculties were asked (1) to respond to the definitions and expected competencies in terms of their appropriateness and applicability to their program in the light of their philosophy; (2) whether or not the competencies provided direction for evaluation; (3) to give information regarding the use made by faculties of the project definitions and expected competencies.

Certain issues arose out of the faculties' responses to the first question:

A. Are the definitions of each of the following terms applicable to your program in the light of the philosophy of your department or school? If not, please explain.
    1. Beginning first-level practitioner in nursing.
    2. Beginning first-level practitioner in nursing care of the mentally ill.

These issues were a matter of question or disagreement on the part of particular schools within the two types of programs. They could be seen as basic philosophical differences with the underlying assumptions and philosophy of the project. The differences, according to the type of program, were as follows.

Associate Degree Programs:

There had been question earlier in the project among some faculty in the associate degree programs as to whether associate degree nursing education should prepare students for beginning first-level practice in nursing care of the mentally ill. The alternative was that the students would be primarily prepared to begin functioning in a general hospital setting with medical-surgical patients and that the purpose of the course or unit in nursing care of the mentally ill would be for understanding behavior.

At the time of the last visit, all programs agreed that they should prepare their students to work with the mentally ill. One program said that they were preparing their students for team leadership in order to meet the needs of the community.

Diploma Programs:

The largest area of disagreement among diploma programs themselves was whether or not their students should be prepared to function as team leaders as part of beginning first-level practice. Some stated that their graduates were prepared to manage personnel and patients on the units and that team leadership was not head nursing. After this orientation, the diploma graduate related to the interdisciplinary team as a nursing team leader, but these programs did not see nurses as co-workers with the physicians. Other diploma programs said that the diploma student should be prepared as a nursing team member and that the baccalaureate student should be prepared as a team leader. Other comments were that the diploma graduate did not need to function under continual supervision or could not because of the shortage of nursing personnel. Some programs felt that the diploma graduate needed supervision, while others said that she was supervised by the head nurse, not by a graduate of a baccalaureate program.

Another major issue was whether or not the graduate of a diploma program is a technical-level nurse, or whether diploma educational programs were technical programs. Faculty in some programs predicted that two levels of practice would occur in the future. One program felt that the diploma graduate was a semiprofessional nurse, while two others stated that she was a professional nurse and that there was no difference between the baccalaureate and the diploma graduate. One said that the diploma graduate had more skills than the associate degree graduate, while two stated that they were not familiar with associate degree nursing education and had never seen a graduate of that type of program at work.

One program said that the project's expected competencies fitted the baccalaureate graduate as well, while another said that any aide could do these things. There was also dispute as to whether or not diploma graduates were prepared to give other than in-patient care. Some felt that in view of the current trend toward extramural health care, diploma graduates must be prepared to function in extended care programs. Some of the diploma programs said that the expectations of the employing agencies determined the content of their educational program.

Both Types of Programs:

Some of both types of programs stated that it was difficult to use the course in general psychology and the course in general sociology as a foundation for psychiatric-mental health nursing content because of their curriculum structure and difficulties in keeping abreast of the content changes in these two courses. The alternatives were to view these courses as supportive or as part of a liberal background. Nevertheless, they felt that these courses should be foundational.

Many programs found it difficult to provide laboratory experience in the nurse-patient relationship, in working with groups of patients, and in participating in interdisciplinary team discussions as a nursing team member in the general and psychiatric hospital because of agency restrictions; *i.e.*, lack of community agencies, lack of facilities in the agency, lack of cooperation of nursing service personnel and other health team members, and lack of preparation of nursing service personnel and other health team members. One of each type of program questioned whether mental health and mental illness were on a continuum or were separate entities.

Other issues that arose were (1) whether or not diploma or associate degree education should prepare the student to work with groups of mentally ill patients, as in discussion or recreational groups and (2) whether content and learning experiences related to group functioning and the therapeutic environment should be integrated throughout the curriculum or be placed in psychiatric nursing.

Following is a summary of the schools' responses to the question, Do the competencies provide direction for evaluation of students?

	Associate Degree	Diploma
1. They *do* provide direction for evaluation	5	5
a. Faculty must have a common understanding of the terminology used.		
b. They should be more specific.		
c. They provide some direction only or some provide more direction than others.		
d. They need to be broken down more.		
e. Determining critical incidents is helpful.		
f. Could be a basis for an evaluation tool.		
2. They *do not* provide direction for evaluation	3	2
a. The instructor must be present for evaluation.		
b. Evaluation tools are needed.		
c. They cannot be used with the present evaluation tools.		
d. They require too many inferences and judgments.		
e. They are too broad.		
f. They cannot be used directly.		
g. There are no yes or no answers.		
h. They should be broken down by levels or by courses.		

During the final follow-up visit, schools were again asked about the use they made of the suggested expected competencies and definitions while planning for integration. The schools reported that the competencies had provided a focus for planning for integration in their curriculums; *i.e.*, they were used as a resource or a basis for discussion when developing their own expected competencies. Some faculties were able to incorporate the project competencies directly or in a modified form within their curriculums, while others said that they could only be used as a pattern or for direction. In general, schools said that the project competencies helped clarify their thinking and were useful in determining placement of content categories. Some faculty members disagreed with some of the expected competencies on a philosophical basis.

The project definitions helped faculty to have a common frame of reference; i.e., they were used as a resource or a guide by faculty when coming to agreement on terminology. It was generally agreed that faculties should develop their own definitions. Definitions were needed for clarification when they were writing their competencies. Again, some faculty members disagreed with some of the project definitions on a philosophical basis.

The project plan included the publication of guidelines and resource materials for use in the development of course offerings and the selection of educational resources in psychiatric-mental health nursing in diploma and associate degree nursing education programs.* The definitions and expected competencies developed within the project are a part of such materials and are included in this report (see Appendixes E and F) as well as in earlier project publications. Many suggestions from faculties of the participating programs regarding the project competencies and definitions, as well as suggestions made after their evaluation of the proposed method of planning for integration, have been incorporated in this report, the final publication of the project.

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*Published in 1968 under the title An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: A Method for Content Integration and Course Development in the Curriculum.

Reference

1. Educational Preparation for Nurse Practitioners and Assistants to Nurses: A Position Paper. New York, American Nurses' Association, 1965.

TESTING AND EVALUATION OF THE METHOD AND MATERIALS THROUGH APPLICATION IN THE PARTICIPATING PROGRAMS (1966-67)*

The third phase of the project was concerned with the utilization by the participating programs of the proposed method of planning for integration of psychiatric- mental health nursing content within the curriculum and for the course or unit in psychiatric nursing or nursing care of the mentally ill.

WORKSHOP

As a first step in this phase, a workshop was planned for representatives of the participating programs. The purpose of the workshop was to provide the representatives with direction in using the project method of developing psychiatric-mental health nursing content throughout the curriculums of basic programs in nursing education. Prior to the workshop, one diploma school asked to be dropped from the project because of faculty turnover.

In preparation for their participation in the workshop, faculties were sent a selected bibliography and a questionnaire for discussion and completion prior to the workshop.** The primary purpose of the questionnaire was twofold--to have the total faculty think through its beliefs relative to psychiatric-mental health nursing content and to assess how this content was currently being taught in its curriculum. An additional purpose was to give the faculties an opportunity to practice the mechanics of tracing a thread of content throughout the curriculum through the use of the same worksheets their representatives would be using at the workshop.

The rationale underlying the formulation and completion of the questionnaire prior to the workshop was not only to provide those designated to attend with a frame of reference but also to strongly encourage total faculty involvement through intrafaculty discussion, so that the workshop participants would be truly representative of their faculty. This was an important step, since it would be those persons who would bring back to their respective programs information about the workshop proceedings and who would carry most of the responsibility for directing the faculty as a whole in the task of following through on the use of the project method of planning for integration and the course in their schools and departments.

The completed questionnaires were returned to the project staff prior to the workshop. The responses were used as a means of helping the staff and resource people to gear their activities at the workshop to the individualized needs of the schools insofar as was possible.

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*An adaptation of this section appears in the November 1968 issue of Nursing Outlook under the title "Integrating Psychiatric-Mental Health Nursing Content in the Curriculum," by Joan E. Walsh and Cecelia Monat Taylor. See also An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Nursing Programs: Workshop Report. New York, National League for Nursing, 1967.

**The questionnaire appears in An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: Workshop Report. New York, National League for Nursing, 1967.

The workshop itself was held for five consecutive days. Each project school was represented by two faculty members. With the exceptions listed below, the associate degree programs were represented by the psychiatric nursing instructor and the instructor who worked most closely with her. Also with exceptions, the diploma school participants were the psychiatric nursing instructor and the curriculum coordinator. Exceptions in the associate degree representation were:

1. Two programs sent both instructors in psychiatric nursing.
2. A department chairman of one program attended in the role of a faculty representative.
3. Three programs that had no faculty member with advanced preparation in psychiatric nursing sent the instructor who was responsible for the course or unit as their first representative.

Exceptions in the diploma school representation were:

1. Three schools that had no faculty member with advanced preparation in psychiatric nursing sent the instructor who was responsible for the course or unit as their first representative.
2. Two schools sent as their second representative an instructor who had dual responsibilities.

Since the stated purpose of the workshop was for the representatives to become familiar with and practice the project method of developing psychiatric-mental health nursing content throughout a curriculum, formal speeches were kept to a minimum so as to allow maximum time for actual work by the group. During formal presentations, the entire group met together; during the work sessions, representatives of the associate degree programs and diploma schools worked separately in small groups. Each group but one consisted of the representatives of two programs and a qualified resource person, the exception being that the representatives of three diploma schools worked together at one table. One group worked with different resource people, but at all other tables the same resource people were present throughout the week. The project staff acted as "floating" resource people. In addition, there were NLN staff from the Department of Associate Degree Programs and the Department of Diploma Programs. The Nursing Section of the Training and Manpower Resources Branch of the National Institute of Mental Health was also represented.

The keynote speaker was Mona Moughton, Instructor, Division of Nurse Education, New York University, who spoke to the topic "Integration of Psychiatric-Mental Health Nursing Content in a Curriculum." The other guest speaker was Wallace Mandell, Ph.D., Director, Research Division, Staten Island Mental Health Society. Dr. Mandell's subject was "The Trend Toward Community Mental Health Centers." The subjects of the other presentations were "Individual Behavior and the Nurse-Patient Relationship" and "The Group Process." These presentations were concerned not only with content related to the respective topics but also with the proposed method of planning and teaching this content in an integrated manner throughout the curriculum.

Each of the last two presentations was followed by a work session, during which each small group worked on the development of expected competencies related to the topic of the presentation. They were instructed to begin with terminal expected competencies and then progress to course or level competencies. From these competencies, the faculty representatives then began the development of content and learning experiences progressing sequentially in depth throughout the curriculum. The participants were continually reminded that the philosophy and objectives of their respective programs needed to be kept in mind as they worked.

There was wide variation in the material produced by the groups during the workshop. However, all participants achieved the primary objective of the workshop--namely, to practice the project method of planning for the integration of psychiatric-mental health nursing content and for the course or unit in psychiatric nursing or nursing care of the mentally ill.

Tentative plans were made by the representatives regarding their respective faculties' utilization of the project method and materials. These plans were, of necessity, subject to revision and approval of the entire faculty and the director upon the representatives' return to their schools. Resource materials in the form of definitions, suggested expected competencies, worksheets, and bibliographies were provided for the use of the faculties.

Subsequent to the workshop, the tentative plans were categorized and summarized by project staff as follows.

Associate Degree Programs	Number of Programs
A. Faculty Structure and Procedure	
1. Help faculty to see value of integration for themselves	1
2. Ask faculty's assistance in revising psychiatric nursing course on basis of mental health integration in other areas	1
3. Have psychiatric instructor spend more time in other clinical areas	1
4. Invite psychosocial science people to various meetings to see what is in their course--transfer to nursing or communicate with them	2
5. Seek total faculty involvement in the process	2
6. Define terms	1
7. Use own worksheets with three headings: Behavioral Objectives, Content, Learning Experiences	1
8. Work with first-year instructors one hour a week for implementation of materials developed at the workshop	1
9. Initiate inservice education for other faculty	3
10. Use resource person in dynamics of group process to help faculty work better together	1
11. Proceed slowly	2
12. Report to faculty on workshop process	1
B. Terminal Expected Competencies and Level Competencies	
1. State more specifically competencies of over-all program and each course	1

2. Write competencies 3

3. Spell out competencies for group work (should be on interpersonal relationships first) 1

C. Progression of Content

1. Identify areas of mental health content in each course 1

2. Develop course outlines that identify and include mental health concepts more fully 1

3. Break competencies down for end of each content area in nursing . . 1

4. Build on material gained by student in other areas and disciplines . . 2

5. Reorganize course work in nursing and behavioral sciences to include content and learning experiences in nurse-patient relationship, process recording, and group process 1

6. Consider content in terms of level of student 1

7. Identify content and select learning experiences for various levels . 1

8. Identify content from the psychosocial sciences appropriate for integration 1

9. Concentrate on group process and add experiences in working with groups for entire curriculum 3

10. Transfer appropriate interpersonal relations content to earlier semesters 1

11. Develop content on individual behavior throughout curriculum . . . 1

12. Separate content from unit in psychiatric nursing for integration in other nursing courses 1

13. Increase communication among faculty. Find out what is in each nursing course, so that content can progress in depth without duplication 1

14. Design learning experiences that will better correlate with content learned in the classroom 1

15. Develop interpersonal relations content 1

D. Course in Psychiatric Nursing

1. Revise psychiatric nursing course on basis of mental health integration in other areas 2

2. Concentrate on nurse-patient relationship, process recording, and group process in course in psychiatric nursing 1

Diploma Programs

A. Faculty Structure and Procedure

1. Have faculty work in small groups first, then as total group 1

2. Work through curriculum committee 1
3. Work together as a group on (1) integration of mental health content in all courses and (2) identification of over-all competencies 2
4. Have instructors in psychology and sociology attend curriculum meetings 1
5. Initiate inservice education for faculty on group process and content. 1
6. Have faculty define terms, so that all will have same frame of reference 1
7. Have psychiatric instructors work more closely with faculty in planning content 1
8. Work integration of mental health concepts in with curriculum revisions already in progress 2
9. Work around what we already have--no major curriculum changes. . 1
10. Identify over-all competencies, and revise philosophy and objectives accordingly 1
11. Have faculty identify mental health concepts as a first step 3
12. Have faculty identify content already included in the nonpsychiatric areas. 1
13. Work more closely with the cooperating agency 1
14. Have psychiatric faculty of cooperating agencies participate in orientation of students to psychiatric nursing prior to the course . . 1
15. Utilize team teaching. 1

B. Terminal Expected Competencies and Level Competencies

1. Express mental health concepts in objectives and expected competencies 4
2. Establish expected competencies for working with groups of patients or for one strand of content 2
3. Work on level competencies. 2
4. Use critical incidents--competencies for evaluation 2

C. Progression of Content

1. Use worksheets 3
2. Show progression of learning in curriculum 1
3. Break down content into knowledges, skills, et cetera 1
4. Begin integration of psychiatric-mental health concepts in Fundamentals 2
5. Have faculty consider content and learning experiences that precede psychiatric nursing. 1

6. Follow up on course in psychiatric nursing	1
7. Introduce group process in other clinical areas	1
8. Add content on therapeutic environment to clinical nursing courses	1
9. Identify and include more mental health content in course outlines and nursing care plans	1
10. Develop use of process recordings and group conferences	2
11. Identify content on group process and utilize lab more effectively	1
12. Include more on student self-awareness in the curriculum	1

D. Course in Psychiatric Nursing

1. Work on expected competencies and objectives for the course in psychiatric nursing	2
2. Build on the content the student has had when she comes to psychiatric nursing	1
3. Discuss placement of the psychiatric nursing course and perhaps move the course to the third year	3
4. Focus psychiatric nursing content more on mental illness	1
5. Include content and learning experience on group process in the course in psychiatric nursing	2
6. Focus more on interdisciplinary team functioning in the course in psychiatric nursing	1
7. Define learning experiences more specifically on the basis of preceding learning	2
8. Utilize home visits in the course in psychiatric nursing	1

The participants were asked to complete a form for their evaluation of the workshop and turn it in at the end of the workshop.* Among other things, the faculty representatives were asked to state the problems they anticipated their faculties might encounter in integrating psychiatric-mental health nursing content throughout the curriculum and in modifying the course. Following is a summary of their responses.

1. Placement of the course in psychiatric nursing in the curriculum.
2. Reinforcement and follow-up of content from the course in psychiatric nursing in the remainder of the student's program.
3. Faculty see psychiatric nursing as a specialty, as opposed to being nursing care of the mentally ill.

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*For evaluation form, see An Approach to the Teaching of Psychiatric Nursing in Diploma and Associate Degree Programs: Workshop Report. New York, National League for Nursing, 1967, p. 61.

4. The frame of reference for the teaching of psychiatric nursing is different from that for the teaching of the mental health aspects of the other nursing courses.
5. Psychiatric nursing is planned separately from the rest of the curriculum.
6. Articulation of courses.
7. Getting faculty to plan their courses together instead of separately.
8. Placement of the courses in psychology and sociology in the curriculum.
9. Keeping abreast of changes in the course content of psychology and sociology.
10. Disagreement among faculty over expected level of functioning of their graduates.
11. Faculty attitudes toward the role of the nurse in working with groups and recognition of the importance of considering group dynamics in their own courses.
12. Faculty is already in the process of making curriculum and/or course revisions,and it will be difficult to introduce the process of integration at this time.
13. Faculty recognition of the importance of using process recordings in their own courses and learning how to use them.
14. Necessity of changing the attitudes of the nursing service staff toward students' learning of skills in interpersonal relationships in the clinical laboratory.

POST-WORKSHOP ACTIVITIES

After the workshop, project staff made site visits to the participating programs as consultants to assist faculties in their implementation of the project method. At the end of the year, faculties were asked to submit their plans on the worksheets to the project staff. An analysis of the worksheets showed that the progress made by the participating programs to date was as follows.

Associate Degree Programs	Number of Programs
1. Developed over-all objectives and terminal competencies for entire program	1
2. Worked on terminal expected competencies for:	
a. Group process	2
b. Mental health	1
c. Nurse-patient relationship	1
d. Interpersonal relationships	1
e. Communication	1
f. Therapeutic environment	1

3. Developed expected competencies related to interpersonal relationships for fundamentals of nursing and psychiatric nursing only	1
4. Developed expected competencies for each clinical course	4
5. Developed competencies for different aspects of different courses	1
6. Developed content, et cetera, for fundamentals of nursing only	1
7. Developed content, et cetera, for maternal and child health nursing only	1
8. Developed content for therapeutic environment only	2
9. Developed competencies for the entire course in psychiatric nursing	2
10. Listed psychosocial "concepts" reflected in the curriculum	1

Diploma Programs

1. Developed competencies and content for the entire mental health and psychiatric nursing area	1
2. Worked on terminal expected competencies and level competencies for:	
a. Group process, interpersonal relationships, therapeutic environment	1
b. Group process	2
c. Nurse-patient relationship	1
d. Self-awareness	1
3. Developed expected competencies for the end of the first year (level) and for each first-year nursing course	1
4. Developed competencies for each course only	1
5. Developed content, et cetera, for group process, team nursing, and psychiatric nursing only	1
6. Developed competencies for the entire course in psychiatric nursing	2

The following year, staff again made visits to the participating programs for the following purposes.

1. To ascertain the progress faculties had made.
2. To further assist them in implementing their plans.
3. To learn the faculties' evaluation of the method of planning.
4. To elicit a description of the use made of the project materials by faculties (see pages 22-23).
5. To ascertain their evaluation of the project as a whole.
6. To further discuss the issues that arose as a result of their responses to the questions on the definitions and competencies (see pages 21-22).
7. To request suggestions for the content of the guidelines to be published as an outcome of the project.

During the last follow-up visit, the director, the workshop participants, and finally the total faculty of each program were asked to describe what actual implementation of their plans for integration of psychiatric-mental health nursing content in their curriculums they had been able to accomplish during the year between the workshop and the final visit. They were also asked to describe their projected plans for continuing implementation and to state any problems they had encountered in their implementation to date.

A compilation of the schools' responses follows. The substance of their reports has been divided into that related to philosophy and objectives, that related to curriculum structure, that related to the course or unit in psychiatric nursing or nursing care of the mentally ill, and that related to other nursing courses.

Associate Degree Programs

Three of the eight participating programs had rewritten their curriculum objectives in the form of terminal expected competencies, which included competencies related to interpersonal relationships. Two other programs had proposed changes in their philosophy and objectives, and the sixth program was planning to review its curriculum for the purpose of identifying threads of content in order to write terminal expected competencies. Another program was working within its existing philosophy and terminal competencies. The eighth program planned to include a statement in its philosophy that would reflect its belief that the program prepared students to function as beginning first-level practitioners in the nursing care of patients with major health problems, including mental illness.

Some structural changes in the curriculums of these programs had occurred or had been proposed. One was planning to add a course in general sociology. Another was moving the course in general psychology to the first quarter so that some of the content from the course could be used as a basis for content related to the psychiatric-mental health nursing aspects of patient care in the nursing courses. Two programs were dropping their required course in growth and development because of overlapping of content with the course in maternal and child health nursing. In two other programs, the course in growth and development had been moved so that it would be concurrent with the course in maternal and child health nursing.

One program had changed its general approach to teaching from diseases to body reactions and from nursing procedures to patient needs and nursing problems. In another, the framework of age groups and major health problems, with the approach of stress and adaptation as a process of life, had been adopted for the second year. Two other programs were considering the use of this general framework. One program was considering the use of the 21 nursing problems as an organizational structure for its curriculum, while another was planning to integrate other threads of content through the project approach.

With respect to incorporating into their curriculums the competencies and content that they had listed on their worksheets, the eight nursing departments are dealt with separately for clarity.

The first nursing department had written terminal expected competencies for the nurse-patient relationship, working with groups, and the therapeutic environment. Course competencies, content, and learning experiences for working with groups had been included in fundamentals of nursing and in maternal and child health nursing. Plans had been made for continuing integration of this content area in medical-surgical nursing and psychiatric nursing. Expected behaviors had been written for the courses in maternal and child health nursing and medical-surgical nursing. It was planned that the same would be done for psychiatric nursing. The maternal and child health nursing course had been reorganized to incorporate content on growth and development and to delete content on the ill child, which was to be included in medical-surgical nursing. As part of their laboratory experience, students were to work with one patient while studying the nurse-patient relationship. Plans had been made for building on this content and experience in the medical-surgical nursing and psychiatric nursing courses.

Another program had developed terminal expected competencies and course competencies for "mental health aspects," using Jahoda's concepts.[1] Content and learning experiences for each course had been determined, starting with the positive aspects of the mental health of students that would be reflected in their patient care. Expected competencies for the entire course in psychiatric nursing had been developed but remained to be implemented in full. The faculty had learned what mental health content was included in the required general education courses and was planning to identify all of the psychiatric-mental health nursing content currently in their nursing courses. Content on anxiety and the defense mechanisms had been included in fundamentals of nursing, and the sections on communications had been strengthened in this course. This content had been built upon in the course in maternal and child health nursing,and additional content on the psychological aspects of adolescence, motherhood, and infancy had been included to supplement and build on the course in growth and development of the child.

The third program had identified psychosocial concepts reflected in its curriculum and had developed a tool to facilitate the development of terminal expected competencies for the entire program. Expected competencies for interpersonal relationships and communication skills had been written for the courses in fundamentals of nursing and psychiatric nursing and for the therapeutic environment for the courses in psychiatric nursing and medical-surgical nursing. Related content and learning experiences had been determined and included in these courses. Additional content related to the psychiatric-mental health nursing aspects of patient care had been included in the course in medical-surgical nursing. It had been planned that an instructor in psychiatric nursing would work with the faculty responsible for the courses in maternity nursing and pediatric nursing to assist them in planning for integration of psychiatric-mental health nursing content. Faculty had planned to pull together the work they had done in integration thus far.

Another program had written terminal expected competencies for working with groups. Competencies for each course had been determined, as well as content and learning experiences to be included in the nursing courses. Behavioral objectives had also been written for each unit of the courses and each laboratory experience. The focus in the first year was on student group interactions. The second year had been revised so that the content areas of nursing care of the physically and mentally ill patient and of the mother and newborn were concurrent and sequential. Group aspects were covered through content and experience related to working with groups of mentally ill patients, to teaching groups of patients, and to team nursing. In addition, behavioral objectives had been written for a course in interpersonal relationships that ran parallel to the course in fundamentals of nursing. Guidelines for the development of a nurse-patient relationship in the content area of nursing care of the mentally ill had been developed. It had been planned that the faculty would continue their development of competencies and determination of content and learning experiences in interpersonal relationships and communication skills, with emphasis on evaluation of these skills. They had also planned to work on the area of the nurse's role in a therapeutic environment.

The fifth nursing department had written program and course objectives in behavioral terms related to interpersonal relationships, to the understanding of behavior, and to communication skills. For the fundamentals of nursing course, content had been indicated and related objectives had been written for each laboratory experience. It had been planned that the content would be built upon in the second year.

In another nursing department, objectives had been rewritten in the form of terminal expected competencies. These included competencies related to interpersonal relationships and communication skills, which had also been written for each nursing course. Related content and laboratory experiences had been included in the course in fundamentals of nursing. The projected plans were to continue revising the competencies, focusing on those related to attitudes and appreciations. The content in the course in general psychology that could be used as a foundation for psychiatric-mental health nursing content in the curriculum had been identified. Other objectives and content in psychiatric-mental health nursing in general had been added to the course outlines as they continued to look for gaps and overlap. Process recordings were being used as teaching tools in laboratory experiences in all nursing courses. Plans had been made to include group dynamics content and experience prior to the course in psychiatric nursing.

The seventh program had worked out terminal expected competencies for the therapeutic environment, as well as course competencies, content, and learning experiences related to the therapeutic environment for all clinical nursing courses. Expected competencies had been written for the entire course in fundamentals of nursing, which included knowledges related to personality development. Content and learning experiences in group dynamics had been included in this course as well as that in psychiatric nursing. In addition to the inclusion of content and experiences in the therapeutic environment in the other nursing courses, there was more focus on psychiatric-mental health nursing content in the courses in medical-surgical nursing and maternal and child health nursing. Process recordings were being used as teaching tools in the laboratory experiences in all nursing courses. Also, the program had planned to develop terminal expected competencies, et cetera, for interpersonal relationships and working with groups.

In the last associate degree program, terminal expected competencies had been written for interpersonal relationships in general and for the nurse-patient relationship. Expected competencies for the entire courses in fundamentals of nursing and psychiatric nursing had been written. It was planned that this would be done for other nursing courses. Content in the course in general psychology that could be used as a basis for psychiatric-mental health nursing content in the nursing courses had been identified and utilized in this manner. Content and learning experiences in the nurse-patient relationship had been added to each unit in maternal and child health nursing. Such content and experiences had been designed to build on prior knowledges and abilities and was to be further developed in psychiatric nursing. It had been planned that the faculty would evaluate what it had accomplished in integration thus far and would begin to work on expected competencies, et cetera, for working with groups.

With respect to the laboratory experiences, one department had increased the time to two days per week in all courses, which provided the students with an opportunity to follow through with one patient. In another program, laboratory experiences had been correlated with class content and therefore the experiences that were provided for each student were similar. One faculty group had planned to use several settings for laboratory experience.

In general, the programs reported that interpersonal relationships with patients were discussed more frequently than before in post conferences and that nursing care plans included more consideration of the psychiatric-mental health nursing aspects of patient care. The use of process recordings as a teaching tool had been introduced in the nursing courses in several departments. In addition, more attention was being given to student group interaction in post conferences.

In regard to student evaluation, one program had developed a "behavioral evaluation guide" on the basis of its course competencies, while another was planning to develop an evaluation tool based on its competencies and to identify some critical incidents. This school was currently using its competencies to determine final grades. A third program was planning to change its clinical grading system to pass or fail on the basis of the critical incident technique. Instructors in one program had worked out a tool for evaluation of the student's ability in the nurse-patient relationship.

With respect to faculty inservice education, one program had held a curriculum study workshop, while others had met weekly to develop competencies and plan for integration. Some faculties stated that they were using each other continuously as resource persons but still planned to improve on their intrafaculty communication. One faculty reported that it planned to hold an inservice program on psychiatric-mental health nursing content. In some of the programs where instructors with advanced preparation in psychiatric nursing were employed, those instructors were assisting other faculty in planning for and including psychiatric-mental health nursing content in their courses, often through team teaching. (Three of the eight programs did not have prepared faculty in psychiatric nursing.)

Prior to participation in the project, three programs did not believe, for various reasons, that they were preparing their students for beginning first-level practice in nursing care of the mentally ill. At that time, two of these programs included the content area of psychiatric nursing as a unit in their course in nursing in physical and mental illness. One of these stated that the content area on nursing care of the mentally ill had been strengthened as a result of project participation. The third program had changed to the belief that it was preparing for beginning first-level practice in nursing care of the mentally ill and was considering including the content and learning experiences as a unit in nursing in physical and mental illness. Three other programs were considering this move, also,and planned to use the team-teaching approach. One nursing department had decreased the length of the unit on the basis of prior integration of content, and another was considering this change. Two had moved the course or unit to a later period in the curriculum, and another was considering a similar move. One program had planned to retain the course in the second semester of the first year.

The instructor in one program had decided to use the nurse-patient relationship as a framework for teaching the content area of nursing care of the mentally ill. The instructor felt that she was now definitely able to go into greater depth because of the content and learning experiences that had been integrated in the prior courses. Faculty of two other programs felt that they were able to go into greater depth in the nurse-patient relationship for the same reason. Two additional programs felt that the focus of their course in psychiatric nursing would be different on this same basis and would also be more related to the rest of the curriculum. However, these faculties had not made changes as yet. The three other programs had not made any major changes but had projected some. Two that had made major changes did not plan additional ones because of proposed total curriculum changes. Instructors in two departments had written expected competencies for the entire course or unit in psychiatric nursing, and one school had planned to do so in the near future.

In regard to the course or unit in psychiatric nursing, three programs had made actual content additions relative to working with groups of patients and the role of the nurse in the therapeutic environment and had also provided appropriate laboratory experiences. Two programs had placed more emphasis on student group interactions in post conferences, and another two had provided opportunities for students to work with groups of patients directed toward remotivation. Faculty in two programs felt that they were making better use in general of their laboratory experience in psychiatric nursing. Three had planned to have more clinical time. Three reported that they were now using more than one cooperating agency for their clinical experiences. One had updated its contract with the cooperating agency that provided clinical laboratory facilities for their students.

Diploma Programs

Seven hospital schools participated in this last phase of the project, one having dropped out of the project just before the workshop because of faculty turnover. Of these programs, two had considered their philosophy and school objectives while writing their curriculum objectives as terminal expected competencies. One faculty group had introduced new organizing threads and terminal behaviors into its curriculum and as a result, planned to rewrite the philosophy and objectives of the program. One school had fitted the project expected competencies in with its curriculum objectives and so had not proposed any changes in its philosophy and program objectives. One had written terminal expected competencies but had not yet implemented them. Two programs had not written terminal expected competencies as yet. Three programs had neither made nor proposed any changes in their philosophy and objectives. There was the possibility that these programs would discontinue as diploma programs in the future, which was also the case with two others.

One program had added a college course in growth and development to its curriculum, while another had dropped the course. A third had moved the course to the first year so that the content would precede the course in maternal and child health nursing. This program had also moved its college course in general psychology to the first year so that it could be used as a basis for psychiatric-mental health nursing content in the nursing courses. Another program reported that it was planning to examine its second course in psychology for overlap and duplication of content with content in the clinical nursing courses. In relation to the general focus or structure of the curriculum, faculty of three programs stated that they were now less nursing-procedure oriented in their courses and instead were concentrating more on the patient as an individual with needs. One of these schools was considering the use of the nursing-problem approach to their curriculum instead of the systems-disease approach.

Activities of the diploma programs in carrying out their plans for integration of psychiatric-mental health nursing content in their curriculums are reported separately, as were those of the associate degree programs.

The first school had not yet written terminal expected competencies, but the faculty was planning to develop them. Expected competencies had been planned for the first level, and content and laboratory experiences related to interpersonal relationships had been planned for the courses in this level. This had been accomplished through a study of already existing content. Course outlines for the first level had been changed, and the faculty believed that students' feelings were now receiving more consideration. The next step this faculty planned to undertake was to examine all the content in the curriculum pertaining to interpersonal relationships, by levels of the curriculum. The same procedure was to be used later for the content on working with groups. This program had affiliation arrangements for psychiatric nursing and pediatric nursing. The faculty intended to work more closely with the agencies in planning for building on student learnings from the affiliation experience in the rest of the curriculum.

The second program had introduced into the curriculum several new integrative threads related to the psychiatric-mental health nursing aspects of nursing care--e.g., working with groups, interpersonal relationships, and the therapeutic environment. Expected behaviors, content, and learning experiences for these threads had been identified and introduced into the curriculum by levels and by courses, with progression in depth and sequence. Also, objectives for lectures and laboratory experiences had been rewritten. The problem-solving approach had been introduced in student discussion groups. The use of process recordings as a teaching tool had been introduced in the courses in fundamentals of patient care, community nursing, and psychiatric nursing. Students were now following up on their learnings from psychiatric nursing in the nurse-patient relationship in community nursing. The instructor in psychiatric nursing was participating in clinical conferences in other nursing courses. An example of implementation of the project method in this school in the area of working with groups can be described as follows: Content and experience in group interaction through student discussion groups are begun in fundamentals of patient care; the students then have experience in patient group teaching and in remotivation groups of geriatric patients in other courses; and finally, they conduct patient discussion groups in psychiatric nursing. The faculty of this program planned to rewrite all their objectives and to continue in their efforts to define expected behaviors more specifically, particularly for levels within the curriculum. They felt that they needed to work more on the content area of attitudes and appreciations and on content progression in general. Also, they wished to develop some critical incidents for student evaluation.

The next program had written terminal expected competencies and level competencies for the general practice of nursing and for the nurse-patient relationship. Content and learning experiences had been stated in progressive depth. Lesson plans had been rewritten and shared with nursing service. It had been planned that faculty would continue to refine their level competencies. Terminal competencies had also been written for working with groups and the therapeutic environment. The faculty had planned to develop these content areas more fully. The first level of the curriculum of this school included a course in interpersonal relationships. Currently, the course was being taught by the faculty in the first level instead of by the instructor in psychiatric nursing. Faculty were considering including the content from this course as part of the course in fundamentals of nursing. Content from the courses in psychology and sociology was being used as a basis for the psychiatric-mental health nursing content in these courses. Process recordings had been introduced as teaching tools in the course in fundamentals of nursing. In the second level, commonalities and differences between the courses in content and experiences in interpersonal relationships had been determined and course competencies had been rewritten. It had been planned that all psychiatric-mental health nursing content in these courses would be identified so that it might be organized to build on the psychiatric-mental health nursing content in the first level. Psychiatric nursing was presently in the second level but was to be moved to the third. On the basis of prior integration of psychiatric-mental health nursing content, it had been planned that competencies for the entire psychiatric nursing course would be rewritten. In the third level, student knowledges and abilities in the nurse-patient relationship learned in the course in psychiatric nursing were built upon in the student experience in the outpatient department by the instructor in psychiatric nursing. She was also currently teaching the leadership course. Some critical incidents had been identified for the nurse-patient relationship. The faculty planned to evaluate what they had accomplished thus far in integration.

The fourth program had not yet written terminal expected competencies. The instructors had determined the content in their respective courses and then had written expected competencies for the nurse-patient relationship and/or working with groups. Their next step was to be to write level competencies after pulling together their course competencies in these two content areas. The faculty also wished to write expected behaviors for the entire content of all nursing courses. The instructors in the first level had written expected competencies and planned content and learning experiences in interpersonal relationships. Process recordings had been introduced into the course in fundamentals of nursing, and as a result, patient behaviors and needs were given greater consideration in planning for care, as were students' feelings and responses. The faculty was planning to develop competencies for the first level related to working with groups. An instructor in psychiatric nursing had participated in some student group discussions in the fundamentals of nursing course. Content and experience in interpersonal relationships had been included in some second-level courses. It had been planned that instructors would become more familiar with the content in the first level so that it could be built upon. Also, faculty in this level had planned to introduce content on and experiences in working with groups. Expected competencies had been written for the entire course in psychiatric nursing, and the course was to be revised on the basis of prior integrated content. Content and experiences in working with groups had been introduced into the course. Expected competencies, content, and learning experiences for interpersonal relationships and working with groups had been developed for the third level. The competencies were being used for student evaluation. Patient needs and students' reactions were being discussed in clinical conferences, and attention was being given to student group interactions. Group dynamics knowledges were being applied in nursing team conferences in the course on leadership.

The next program had developed terminal expected competencies for the nurse-patient relationship by adapting project materials. The competencies had been broken down by levels and by courses as content and learning experiences were planned. Nursing content had been built upon concepts from the courses in psychology and sociology. Appropriate changes had been made in course outlines. Since the curriculum in this program was based on the disease-systems approach, faculty had introduced the case method of studying patients as one way of including more psychiatric-mental health nursing content. This program had an affiliation arrangement for psychiatric nursing. An instructor from the agency was available to assist the faculty in their plans for integration of psychiatric-mental health content prior to the course. It had been planned that faculty from the home school would work even more closely with the agency faculty in planning for follow-up of learnings from the affiliation experience--e.g., auditing of the course in psychiatric nursing by faculty from the home school. The faculty in the affiliating agency had developed expected competencies, content, and learning experiences for working with groups of patients, and faculty in the third level at the home school had done the same for working with the nursing team. The faculty was planning to evaluate what they had been able to accomplish in integration thus far, as well as to further refine their level competencies.

Faculty of the sixth program had written terminal and level expected competencies for working with groups. They had approached this through a study of the content on interpersonal relationships and group aspects already in their curriculum. Content and learning experiences had been planned in a sequence. Also, content and learning experiences in interpersonal relationships had been added to the course in fundamentals of nursing, whereas previously the program had used the course in psychiatric nursing as a basis for understanding behavior and developing abilities in interpersonal relationships. The second-level courses in maternal and child health nursing, rehabilitation nursing, psychiatric nursing, and community health nursing had been integrated and correlated through team teaching. Core content had been identified, and a variety of settings for clinical laboratory experience were being used. In the third level, some of the content in the course in psychiatric nursing--e.g., content on addictions and organic disorders--had been moved to the course in nursing care of adults and children. The faculty had planned to further refine the level competencies and to evaluate what had been accomplished in integration to date before making any further plans.

The last program had developed terminal expected competencies and level competencies for student awareness of self, behavior, and feelings, as an aspect of the nurse-patient relationship. The content and learning experiences had been planned in a sequence. The plans for integration of this content had not been implemented as yet, but the school intended this to be a goal for the following year. Faculty in the second level had identified the psychiatric-mental health nursing content presently included in their courses.

In regard to the laboratory experiences, clinical conferences were now patient-centered in several programs, and the problem-solving approach was being introduced in group discussions, with more attention being given to student interactions. Process recordings as teaching tools had been introduced in several programs. Two programs had explained their expected competencies to the nursing service personnel in order to elicit their cooperation.

Regarding student evaluation, one program was using its expected competencies for evaluating students' clinical performance on the basis of satisfactory and unsatisfactory. Another program had identified some critical incidents for the nurse-patient relationship. One was planning to revise its student evaluation system, and two others were planning to revise their evaluation tools. One of these and an additional program were planning to determine whether or not their present evaluation devices and methods sufficiently evaluated students' knowledge of psychiatric-mental health nursing content and ability in interpersonal relationships.

In regard to faculty preparation for integrating psychiatric-mental health nursing content throughout the curriculum, three of the programs had used their psychiatric nursing faculty continuously in planning for and integrating this content. One had planned to appoint a subcommittee to be in charge of integration. The faculties of the two programs that had an affiliation arrangement with a nearby psychiatric hospital were maintaining a close working relationship with the faculties of the cooperating agencies. In some instances, faculty from the agency had served as resource persons to the home school in planning the content to precede and to follow the course in psychiatric nursing. Other means by which the schools were planning to assist their own faculty to increase their knowledge and abilities in the area were an inservice program on psychiatric-mental health nursing content, the employment of a mental health coordinator to work with the faculty, and greater use of the psychiatric nursing instructors as resource people and in team teaching. Three schools had faculty with masters degrees in psychiatric nursing. Instructors in the two affiliating agencies were likewise prepared. Each of two additional programs employed an instructor in psychiatric nursing who held a baccalaureate degree with some additional preparation.

One program was thinking of discontinuing psychiatric nursing as a separate course and including the content as a unit of a course in nursing care of adults and children. One program had moved the course from the second to the third year, and another was considering this move. A third school had decided not to move the course from the third year to the second, which it had been considering prior to participation in the project.

Instructors in one program stated that they were able to go into greater depth in the course in psychiatric nursing because of prior integration of content. Three other programs were planning to reconsider what content should be included in the course on this basis, and one was planning to shorten the course.

Three schools stated that their content in the course was now more related to that in the rest of the curriculum. One of these had adopted the problem-solving approach as a framework for the course. Four had written expected competencies for the course, and another was planning to do so. Two programs did not plan to make changes at the present time.

Two programs had added content on working with groups and had included student experiences in conducting patient discussion groups followed by a seminar. Observations of group therapy and patient government meetings had also been added to their experience. Two other programs were planning to include content and experience in this area, and one was planning to further involve the students in interdisciplinary planning. One program had provided opportunity through the hospital's home care program for the students to follow up a discharged patient under supervision for assessment purposes.

In relation to laboratory experience, one school was planning to use multiple community agencies rather than one. Another was planning to include additional field trips to other agencies, and a third was including a one-week experience in a general hospital psychiatric unit in addition to the mental hospital experience. One school and its affiliating agency stated that they had improved on the preaffiliation orientation of students by including a field trip to the agency.

In regard to student evaluation, four of the schools had made plans as follows: to look at evaluation in terms of their expected competencies; to consider the value of identifying critical incidents; to work on methods of evaluating abilities in the nurse-patient relationship; to reexamine evaluation forms. One program had developed some critical incidents for the nurse-patient relationship.

Both Types of Programs

Problems in implementing plans for integration identified by both types of participating programs were as follows.

1. Time to meet together to plan.
2. Time and space to include content and experiences selected for integration in the other nursing courses. (Faculty believed they would have to delete other content.)
3. Lack of intrafaculty communication.
4. Faculty attitudes.

    - a. The perception of the content as threatening or resistance to the area of psychiatric-mental health nursing.
    - b. The lack of belief in the value of integration or resistance to the concept of integration.
    - c. Their procedure-disease orientation.

5. Faculty preparation.
    - a. The need for an inservice education program on the content area of psychiatric-mental health nursing.
    - b. The lack of a prepared psychiatric nursing instructor on the faculty.
    - c. The need for an integrator familiar with curriculum planning.

6. Faculty turnover and rotation.

7. Limited and required course offerings in the college.

8. Instructor turnover and frequent changes in the psychosocial science courses.

9. Difficulty of affiliating agency in building on prior content when it has more than one school affiliation.

10. Student rotations.

11. Resistance of students to behavioral content included in other nursing courses.
    - a. Their preoccupation with learning manual skills and other content.
    - b. Their need for much support when interpersonal relationships content and experiences are included.
    - c. Their difficulty in verbalizing their feelings.

12. Cooperating Agencies.
    - a. Inadequacy of staff nurses as role models.
    - b. Lack of cooperation from nursing service (nursing service needs took precedence).
    - c. Negative attitude of nursing service personnel and medical staff toward student experiences in interpersonal relationships.
    - d. Conflict between what students are taught and what they experience in hospital situations.
        - (1) Nursing care plans.
        - (2) Nursing teams.
        - (3) Interpersonal relationships.

13. Evaluation of students in interpersonal relationships.

Evaluation of the Method and Materials

Faculty in the participating programs were asked to evaluate the project method of planning for integration of psychiatric-mental health nursing content on the basis of their experience in utilizing the method in their respective curriculums.

Following are the advantages of the method as described by programs of both types.

1. It is specific, logical, realistic, and orderly.

2. It is a planned way of going about integration.

3. The method can be used with any curriculum style.

4. It helps in curriculum development in general.

5. It can be used for integrating other threads of content.

6. It creates a framework and a frame of reference within which to plan.

7. The method stimulates the faculty to look at the program as a whole.

8. The method increases intrafaculty communication.

9. The method stimulates faculty to look at the whole area of evaluation.

Faculties agreed that it was beneficial to start with expected outcomes, because competencies stated in behavioral terms were more specific than other forms of objectives. Owing to this specificity, faculty expectations of students were more unified and students knew what was expected of them. Some faculties stated that with their competencies spelled out, they were better able to explain their goals to the nursing service department of the clinical laboratory. Having an objective within an objective was helpful in differentiating expectations for the different semesters.

There was general agreement that by stating expected competencies, direction was provided for determining content and learning experiences. It became clear to faculties that in order to write competencies and determine content, they needed to adopt a theoretical framework within which to work. In addition, the competencies insured inclusion of content. Some faculties were able to state existing content more clearly. In relation to evaluation, faculties said that expected competencies could be used directly for evaluation and that levels of competency could be stated succinctly and in progressive depth. Several faculty groups reported that the use of the critical incident technique was very helpful in student evaluation.

In regard to planning for progression of related content in depth and sequence throughout the curriculum, most faculties said that utilization of the project method of planning enabled them to better provide for this progression. In fact, through use of the method, most faculty groups became familiar with the content in all courses and as a result knew better what to include in their own courses, so that omissions and overlapping of content were avoided. Faculties were also able to determine the content that could be removed from the psychiatric nursing course and decide where the course should be placed in the curriculum. Through having content and learning experiences spelled out, faculty at the affiliating agencies were better informed of the knowledges and abilities students brought with them to the affiliation experience. Also, showing content and learning experiences in progression was helpful in orienting new faculty members. In general, faculties said that the psychiatric-mental health nursing content in the curriculum was more visible as a result of using the project method of planning for integration.

Following are the general disadvantages of the method as reported by programs of both types.

1. The method itself is too time-consuming to use for all the threads of content in the curriculum.

2. The method seems "backward" to faculties who are used to planning content first.

3. It is more advantageous to a new program. Programs in operation must either fit the method to their curriculum or reorganize the curriculum.

4. The method of planning is difficult to implement in a systems-disease approach to curriculum.

5. The method requires continual intrafaculty communication.
6. There are problems in bringing school faculty and agency faculty together for joint planning when affiliations are used.
7. The method is too structured. It restricts the teacher.
8. It is difficult for faculty to always come to agreement on definitions of terms.
9. The entire faculty must believe in the value of integration in order for the method to be used.
10. Using the method of planning is no guarantee it will be implemented by all faculty members.

Several faculties said that in writing expected competencies and selecting and organizing content, level differentiation had been their greatest problem. The difficulty was in determining to what point the students should be taken in each level and course and in so doing, avoid overlapping, duplication, and omission of content. Competencies for the second level were especially difficult to state because of student rotations and affiliations. Three programs reported that competencies were not helpful in selecting content because they were determined on the basis of already existing content. Other faculty groups said that listing content would be endless.

Faculties found that in order to use their expected competencies for student evaluation, they needed to be specific; otherwise, too many inferences were required. Therefore, expected competencies were difficult to state and to use directly for evaluation in all cases. They stated that the critical incident technique was helpful in evaluation but that it was a difficult concept to grasp.

Summaries of the faculties' comments on planning for integration in general indicated that they believed they needed to develop a "philosophy of integration" prior to beginning planning. When this was accomplished, the next step was to establish goals for themselves for integration--i.e., why and how they wanted to plan for it. With goals spelled out, evaluation of their integration program was given direction. Next, planning for integration had to be part of total curriculum planning. Faculties needed to begin by looking at the philosophy and objectives of the institution of which they were a part, and then at the philosophy and objectives of their own program. They found it necessary to plan as a group instead of individually and that it was better to have regular planned meetings to facilitate continuity. Also, faculty members had to agree on the meanings of terms they were using. It was generally agreed that they needed to have a prepared instructor in psychiatric nursing with experience in curriculum planning to work with the faculty, as well as to have inservice education programs on psychiatric-mental health nursing content for faculty.

Reference

1. Marie Jahoda. Current Concepts of Positive Mental Health. Joint Commission on Mental Illness and Health, Monograph Series No. 1. New York, Basic Books, 1958, ch. 3.

EVALUATION OF THE PROJECT AND RECOMMENDATIONS (1967-68)

FINAL EVALUATION BY PARTICIPATING PROGRAMS

The questionnaire sent to participating programs at the beginning of the project (see Appendix B) called for a statement on how the school or department expected to benefit from participation in the project. Following is a summarization of the responses from both types of participating programs.

Goal	Number of Programs
1. Identify mental health aspects	1
2. Improve integration	9
3. Strengthen home program	1
4. Strengthen correlation of psychiatric nursing with experiences that follow.	3
5. Increase mutual planning with agency faculty for preceding and succeeding content and experiences	1
6. Learn to apply principles of psychiatric nursing (interpersonal relationships) to general hospital situations	2
7. Evaluate importance of student attitudes	1
8. Learn new concepts, teaching techniques	4
9. Keep up with trends	1
10. Gain help in planning	1
11. Share with others	2
12. To compare with A.D. programs	1
13. Look at program in relation to others	3
14. Secure inservice education for whole faculty	3
15. Improve interpersonal relationships	1
16. Validate psychiatric nursing content	1
17. Identify functions of diploma graduate in psychiatric nursing	1
18. Develop content	1
19. Identify content on behavior of ill person	1
20. Determine placement of course	1
21. Improve faculty attitudes	1
22. Reevaluation of program	2

23. Learn better use of community resources 1

The original questionnaire also requested the faculty's assessment of the strengths of and problems in the course or unit in psychiatric nursing or nursing care of the mentally ill.

Strengths of the course or unit listed by faculty were as follows.

A. Diploma Programs.

1. Opportunity to work closely with the students through individual conferences on the basis of process recordings.
2. Use of the instructor in the course as a resource person for other clinical courses.
3. Selection of learning experiences on an educational basis.
4. Student group conferences emphasizing the problem-solving approach.
5. Planning and teaching of the course by home school faculty.

B. Associate Degree Programs.

1. Participation of the psychiatric nursing instructor in other courses in a team-teaching relationship.
2. Proximity of the clinical laboratory and other community agencies to the college.
3. Viewing of psychiatric nursing as a part of all nursing.
4. Use of pre- and post-conferences and the careful planning of each laboratory experience.

Following are the problems encountered by faculty instructors.

A. Diploma Programs.

1. Need for more mutual planning with the cooperating agency.
2. Student attitudes toward the mentally ill and faculty attitudes toward the field of psychiatric nursing.
3. Difficulty in defining functions of the graduate in the psychiatric area and in determining expected competencies.
4. Need for further utilization of community resources.
5. Need for interdisciplinary cooperation.
6. Need for inclusion of group work skills.
7. Insufficient time for both individual and group conferences.
8. Rapid turnover of patients or availability of only chronically ill patients.
9. Length and placement of the course.
10. Difficulty in evaluating student's interpersonal skills.
11. Difficulty in determining critical incidents.

12. Different levels of preparation of students in an affiliating program.

13. Difficulty of student application of psychiatric nursing principles to the care of nonpsychiatric patients.

14. Difficulty in identifying mental health concepts and planning for their integration.

15. Repetition of content in the curriculum--e.g., growth and development.

B. Associate Degree Programs.

1. Difficulty in identifying appropriate content.
2. Insufficient utilization of community resources.
3. Length and placement of the course.
4. Difficulty in determining expected competencies.
5. Difficulty in evaluating clinical practice.
6. Custodial care in the hospitals and rapid turnover of patients.
7. Lack of opportunity for students to participate in patient groups or interdisciplinary interaction.

The third section of the questionnaire sent to the participating programs as preparation for the workshop asked the faculty to identify the problems they were currently encountering in defining psychiatric-mental health nursing content for integration throughout their curriculum. The problems identified related to faculty attitudes, preparation, and turnover; time to plan; space in the nursing courses for mental health content; and laboratory facilities. Other problems concerned the content itself. These are listed below.

1. Difficulty in identifying and selecting content, including placement, and in agreeing on essential concepts.
2. Difficulty in deciding what content should be included in the psychiatric nursing course and what should be integrated throughout the curriculum.
3. Overlap and repetition of content and lack of awareness of content taught in other nursing courses on the part of the faculty.
4. The taking of mental health content for granted by faculty and their lack of awareness of their responsibility to include mental health content in their courses.
5. Inability of students to recognize psychological needs of patients, even though these were discussed in all nursing courses.
6. Inability of students to apply concepts learned in psychiatric nursing to the normal patient.
7. Use of psychiatric nursing as a basis for understanding behavior.
8. Difficulty in keeping familiar with the content in the course in psychiatric nursing when affiliations are used.
9. Lack of textbooks, other than those on psychiatric nursing, that include psychiatric-mental health nursing content.

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10. Difficulty in evaluating students' skills in interpersonal relationships in the nursing courses in the absence of content, planned learning experiences, or objectives other than in the psychiatric nursing course.

11. Confusion of students' lack of skill in interpersonal relationships with students' emotional problems.

At the time of the final follow-up visit, the director, the workshop participants, and the total faculty of each participating program were asked the following questions as a means of eliciting their evaluation of the project.

1. Did you gain what you had hoped to gain from participation in the project?
   a. Did participation help you in your stated problems in the course or unit in psychiatric nursing or nursing care of the mentally ill?
   b. Did participation help you in your stated problems in integration of psychiatric-mental health nursing content throughout the curriculum?
2. What benefits to the school or department and to individuals were derived from participation in the project?
3. What problems arose as a result of your school or department's participation in the project?
4. Did the workshop prepare your representatives adequately to work with the faculty in planning for integration?
5. What suggestions do you have for preparing faculties for utilization of the method of planning for integration and the course?

In response to the first question, the majority of the participating programs stated that they had gained what they had hoped to gain from their participation in the project. Their participation had definitely helped them with their problems in integration of psychiatric-mental health nursing content throughout their curriculums. Some of the programs had been able to overcome some of their problems in the course or unit in nursing care of the mentally ill. Others had not had an opportunity to implement their plans for the course or unit as yet. Two programs had encountered structural problems with the course or unit that could not be solved at the time. One program had not solved its related problems through participation in the project.

Following is a summary of the responses to the question regarding benefits to the school from participation in the project.

I. Associate Degree Programs.

A. Philosophy.

1. The project made them rethink what they were doing and see what should be done.
2. They began to question themselves about their own philosphy and their use of terminology.
3. Spelling out what they meant by "technical level" was enlightening.
4. Discussing what was mental health and what was mental illness was an eye-opener.
5. Their own beliefs were validated.

6. They now felt able to prepare a beginning first-level practitioner in nursing care of the mentally ill.

B. Objectives.

1. They developed a new set of objectives.
2. They increased their ability to state expected competencies in behavioral terms.
3. The project pushed them to write expected competencies.
4. The levels had never been spelled out so well.
5. They differentiated behavioral objectives from descriptive objectives.

C. Curriculum Organization.

1. They looked at the total program.
2. They were motivated to improve the curriculum.
3. There was now more focus on mental health concepts in the curriculum.
4. They saw that they could reorganize the curriculum for the betterment of the program.
5. They used the method as a basis for working on content in other areas for integration in the curriculum.

D. Content.

1. They defined and labeled content on interpersonal relationships.
2. They recognized that they had taken mental health content for granted.
3. They added content on the group process to the curriculum.
4. They were now less procedure-and systems-disease oriented.
5. They were forced to write down what they were doing and to look at their own courses.
6. All faculty were now aware of the content in the course in psychiatric nursing.
7. All faculty now knew what content was in each other's courses.

E. Evaluation.

1. They developed a new evaluation form. (See Objectives.)

F. Students.

1. Students were now more alert to patients' needs and more aware of communication and interpersonal relationships.
2. Students were better prepared for psychiatric nursing and looked forward to it.

G. Faculty.

1. Faculty were more conscious of mental health content.
2. They were more committed to including mental health content.
3. The project made them realize that they could not function separately but had to function as a group.
4. They now worked together better.
5. Intrafaculty communication was improved.
6. Faculty came to grips with what they did not know, and they were now anxious to learn.
7. They saw the need for integration and that they needed to do more with integration.
8. If they had not participated, they would never have worked on mental health principles.
9. They had more faith in their own competency as instructors. It helped to know they could do what they did without an instructor in psychiatric nursing.
10. They discovered they had not understood what others were saying and were more aware of the need to define terms.
11. They learned a lot, had new ideas, were jogged out of complacency, and were more motivated.
12. The project was broadening and enriching, and it generated new thought and provided new choices.
13. They were more accepting of psychiatric nursing.
14. They saw that the psychiatric nursing instructor could not do it alone.

II. Diploma Programs.

A. Philosophy.

1. They began to question themselves about their own philosophy of nursing and nursing education.
2. Their own beliefs were validated.

B. Objectives.

1. The project gave them some idea of what the ideal should be.
2. Participation forced them to look at their end product.
3. The project pointed up the need to look at levels and level objectives.
4. They now thought in behavioral terms regarding what they were looking for in students.
5. The project caused them to break down their objectives.

C. Curriculum Organization.

1. They looked at the total program and viewed it from a new approach.
2. They were motivated to improve the curriculum.
3. There was now more focus on mental health concepts in the curriculum.
4. The project method helped in curriculum development in general.
5. The method opened avenues for integration of other threads in the curriculum and served as a tool for curriculum planning.
6. The levels were better correlated.

D. Content.

1. They were clearer as to what mental health content was.
2. They recognized that they had taken mental health content for granted.
3. Their belief that group work is appropriate for diploma education was supported and strengthened.
4. They were now less procedure-and systems-disease oriented.
5. They discovered that course outlines needed to be spelled out more specifically.
6. Psychiatric nursing became part of the curriculum and was no longer seen as separate.
7. All faculty now knew what content was in each other's courses.
8. The project enriched all areas of the curriculum.
9. Courses no longer had distinct boundaries of content.

E. Evaluation.

1. The project caused them to look at their evaluation tool and the whole area of evaluation. (*See* Objectives.)

F. Students.

1. Students were more alert to patients' needs and more aware of communication and interpersonal relationships.
2. Students were better prepared for psychiatric nursing.

G. Faculty.

1. Faculty were more conscious of mental health content.
2. They were more committed to including mental health content.
3. The project made them realize that they could not function separately but had to function as a group.
4. They now worked together better.

5. Intrafaculty communication was improved.

6. The project pointed up their lack of knowledge in psychiatric-mental health nursing.

7. They realized the need for integration, and the project method helped them to see what they were doing in integration.

8. The project gave them guidelines to help with problems in integration of mental health concepts.

9. They now had more respect for each other's knowledge and were more aware of the need to define terms.

10. They learned a lot, had new ideas, and were more motivated.

11. The project was broadening and enriching.

12. They were more accepting of psychiatric nursing.

13. They saw that the psychiatric nursing instructor could not do it alone.

14. The instruction in the course in psychiatric nursing was improved.

15. The faculty were more understanding of students.

16. The faculty were more understanding of patients.

H. Other.

1. They now worked more closely with the affiliating agency--there was more communication and more involvement.

2. They were better able to explain their objectives for interpersonal relationships to the head nurses and physicians.

The responses to the query regarding problems that arose as a result of participation in the project were as follows.

A. Associate Degree Programs.

1. Time.
   - a. It took considerable time.
   - b. It was an additional task on top of an already heavy workload.
   - c. There was not enough time to concentrate on one particular content area.

2. Faculty felt let down--there was not as much new as they had expected--they already had concepts in curriculum.

3. They had wanted to be told what to do and how to do it in the beginning, but later, they realized they would have resented this.

4. Faculty took a long time to settle down and get to work.

5. They needed to commit themselves to work on integration.

6. It gave them something else to argue about.

7. They were not satisfied with the results of their efforts.

8. They needed someone to be released to dig into the project.

9. New faculty had to be oriented to the project.

B. Diploma Programs.

1. Time.
   a. It took considerable time.
   b. It was an additional task on top of an already heavy workload.
   c. They were bound by schedules and by resources. The project called for longer and more frequent work sessions than were possible.

2. Some faculty felt they already knew all of this and were already doing it all; they had hoped to get more out of it than they did.

3. They had thought they would be shown how to integrate.

4. They needed to commit themselves to work on integration.

5. They needed someone to be released to dig into the project.

6. Faculty turnover caused problems with the project.

7. Head nurses and doctors were questioning what the students were doing with the patients in their nurse-patient relationships.

8. They had to fit the project in with ongoing changes in their curriculum.

9. They disagreed with project assumptions, which prevented them from using the project materials.

10. The state board requirements were not in line with the trends in nursing education.

11. Realizing what they were not doing was frustrating.

12. Faculty felt inadequate regarding mental health concepts and had to do homework.

13. Becoming more aware of content in psychiatric nursing did not help programs with an affiliation arrangement to follow up on the content in the rest of the curriculum.

14. It was difficult to meet with faculty from affiliating agencies.

Summarized below are the responses of both types of programs to the question of whether or not the workshop held in conjunction with the project had adequately prepared the representatives to work with their faculties in planning for integration and for the course or unit.

1. The workshop did prepare the representatives adequately to work with their faculties in planning for integration. It prepared them to:
   a. Work as a liaison between project staff and faculty.
   b. Assist other faculty.
   c. Interpret to faculty what was wanted.
   d. Act as leaders of their faculty.
   e. Help faculty to think through what they wanted to do and were doing.

    f. Use the materials and the method.

2. They returned highly enthusiastic and wanted to "integrate" more than ever. The workshop helped them to feel that they were not doing so poorly in their program. They became more convinced than ever of the need for group content. In addition, they were able to see the benefits of the workshop more and more as time went on.

3. The workshop benefited individual participants both professionally and personally. The sharing of ideas with others was most helpful, and it helped the instructors in psychiatric nursing to look beyond their own course.

4. Some criticisms given by workshop participants were that:
    a. They should have had more time to prepare for the workshop.
    b. They had not understood what was to be expected of them at the workshop.
    c. They did not use the preliminary material they had prepared at the workshop.
    d. They should have been given more specific examples.
    e. They should have been given more specific directions regarding the method.
    f. The workshop was too short.
    g. The whole faculty should have attended.
    h. The workshop should have been held earlier in the project.
    i. There should have been more communication between participants at the workshop.

5. Workshop participants and other faculty stated that a great deal was lost when they, the participants, returned. They also said that the role of the participants in their schools after the workshop should have been defined more clearly. They had had unrealistic expectations of themselves and their program. A second workshop, possibly, regionally, with an assignment in between, would have been helpful. Participants could have shared the assignment with others at the second workshop. Or there should have been some means of communication between the participating programs, so that faculties could share as they progressed in their tasks.

The suggestions of the participating programs for preparing faculties for utilization of the method made in response to the final question were as follows.

1. The National League for Nursing should follow up on the project publications with national or regional workshops to explain the material to faculty. Key people in the regions who were involved in the project should be included in order to promote the use of the project method and materials.

2. Faculties should be prepared in the same way in which they were prepared in the project--i.e., through workshops, consultation, and publications.

3. The method to be used for preparing faculties to plan for integration depends upon:
    a. The age of the program.
    b. The size of the faculty.
    c. Educational preparation of the faculty.
    d. Faculty ability to communicate among themselves.

4. In general, individual programs should:
    a. Seek consultation or employ faculty prepared in planning for integration.
    b. Plan an inservice program for their faculty on psychiatric-mental health nursing content and then one on planning for integration.
    c. Form a committee representing all clinical areas to plan for integration.

During the discussions with faculties, additional information that was related to the actual conduct of the project was obtained. The criticisms and suggestions are outlined below.

A. Questionnaires.

1. There was not enough time between receipt of questionnaires and deadlines.
2. The questionnaires were burdensome and contained too much narrative.

B. Worksheets and implementation of the method.

1. Faculties should have been given more specific directions as to what to do in relation to the columns on the worksheets.
2. They should have received validation of their work on the worksheets.
3. They had too much to do in too short a time.
4. They should have received more guidance on how to use the method of planning for integration. Instructions were not sufficiently clear.

C. Follow-up visits.

1. The follow-up visits were helpful, encouraging, and clarifying.
2. Follow-up visits were too laissez-faire and not as constructive as they had hoped.
3. There should have been more frequent follow-up visits for initial guidance as well as later on. This would have provided for more individual assistance.
4. There should have been "workshops" for each faculty focused on how to determine levels, on what content should be integrated, and on what should be in the course.

D. Materials.

1. The method of planning for integration should have been explained to the faculty before they received the study materials.
2. They should have had the materials earlier, and each faculty member should have had a copy.
3. The amount of material was overwhelming.

E. General.

1. There was a time lag between when they agreed to participate and actual involvement in the project.

2. There were periods of relative silence from the project staff, then overwork, then silence again.

3. The project staff should have kept in closer contact with the faculties to keep them informed about what would be expected of them next.

EVALUATION OF THE PROJECT BY THE PROJECT STAFF

As an approach to evaluating the project from their own point of view, the project staff framed three questions on which to focus their thinking. Following are the questions and summaries of their conclusions.

A. Why did some schools move further ahead than others in planning for integration?

   1. The support of the director of the program to the endeavors of the faculty toward planning for integration is imperative.

   2. Channels of communication between the director and the faculty must be firmly established in order for all to be kept informed of progress and plans.

   3. Turnover of key faculty members and of directors, in some instances, may make achievement of goals difficult.

   4. The current status of the program in regard to curriculum development influences the degree to which planning for integration can be accomplished.

   5. The degree of the ability of the faculty to work together as a group, including the ability to communicate with each other, influences the degree to which integration can be accomplished.

   6. The educational preparation of the faculty members, especially that of the instructor responsible for the course or unit in nursing care of the mentally ill, determines how far they can move in planning for integration.

   7. The attitude of the faculty toward the field of psychiatric nursing can make or break an integration project within a school.

   8. Faculty commitment to planning for integration and to increasing their knowledges and abilities through various means is an important factor in successful implementation of an integration program.

B. What were the problems in the administration of the project?

   1. Organization of the project.
      a. It is important that staff who are to conduct a project be involved in the initial planning. In this way, the project plan can be clearly and specifically outlined at the beginning. Scheduling of workshops, consultant group meetings, visits to participating programs, and the sending of questionnaires, et cetera, can also be done early in the project.
      b. In this particular project, it might have been better to have prepared the materials before involving the schools. Had this been the case, the schools could have been clearly shown at the start what their involvement

would be. Also, the schools' having to accomplish so much in implementation in a short period of time could thus have been avoided.

   c. An alternate way of approaching such a project could be to work more closely with a smaller number of schools. If this approach were to be used, a separate plan for each school with individual goals could be established with the schools on the basis of an assessment. Then the progress in each school in using the project method could be evaluated on the basis of the mutual goals. Using a smaller number of schools might make it possible to have a separate workshop for the entire faculty in each school.

2. Within the participating programs.
   a. In a project of this nature, it is important that reports and other communications about the project be shared among the total faculty group. With respect to questionnaires, where total faculty response is called for, it is essential that the question be answered by the total faculty instead of by an individual. The same holds for materials to be discussed by the group.
   b. Other problems that need to be anticipated in a project requiring the participation of schools are turnover of directors and key faculty members, attitudes of faculty members, and lack of qualified faculty.
   c. When a program agrees to take part in a project, it is important that the director and faculty members together set clear goals for their program's participation. In this way, the problem of the director's and individual faculty members' having different goals for their participation can be avoided.

C. Did we achieve the purpose and the goal of the project?

1. The purpose of the project was to determine what goals, content, and learning experiences in psychiatric-mental health nursing should be included in diploma and associate degree education for nursing in the light of present-day trends in nursing and psychiatric care.
   a. Objectives (expected competencies) and a method for determining content, learning experiences, and evaluation methods on the basis of the objectives were developed for this level of nursing education with examples given. These were tested, found to be usable, and subsequently published in the form of guidelines.
   b. The teaching of psychiatric-mental health nursing was improved in the participating programs. It is strongly recommended that a follow-up study be done in these schools to determine whether or not they are able to go ahead with their plans for continuing implementation and whether or not their activities in the project will make an impact in their schools in the future.
   c. There is also the need to determine whether or not the project method and the materials developed within the project will be useful to other programs. It is therefore recommended that a study utilizing other schools be done for this purpose. Inasmuch as the usefulness of the method and materials can be increased through the mechanism of follow-up regional workshops, it is recommended that these, also, be planned.

d. A number of changes occurred within the participating programs other than those related to the utilization of the project method and materials in curriculum and course planning as reported in an earlier section. Some of these changes were as follows.

   (1) In many instances, there was a change on the part of faculty members in their attitudes toward the area of psychiatric nursing.

   (2) The course or unit in psychiatric nursing or nursing care of the mentally ill became an integral part of the curriculum rather than being considered as a specialty requiring special treatment.

   (3) Faculty groups became more aware of the need for integration of psychiatric-mental health nursing content in their curriculums and the need to be specific in including this content.

   (4) In several instances, faculties became aware of their need to increase their knowledges and abilities in the psychiatric-mental health nursing area and took steps to remedy their lacks.

   (5) Faculties saw the need for a plan for integration.

   (6) In most programs, there was increased intrafaculty communication.

   (7) New content, learning experiences, teaching methods, and laboratory facilities were introduced in several courses, including the course or unit in nursing care of the mentally ill, in the participating programs.

   (8) Faculties in some programs were studying their entire curriculums as a result of their activities in the project.

e. In order to determine whether or not integration of psychiatric-mental health nursing concepts and improvements in the course or unit in nursing care of the mentally ill improves students' knowledges and abilities in the area, it is recommended that comparative studies be done of results on the NLN achievement tests, including the psychiatric nursing test, the state board examinations, and teacher-made tests and the findings be disseminated nationally.

2. The goal of the project was to improve the teaching of psychiatric-mental health nursing in diploma and associate degree nursing programs through the development of goals and the selection of content and learning experiences appropriate to this level of education, in the belief that improvement of the teaching process would ultimately lead to better general nursing practice in all settings as well as to increased recruitment of nurses for nursing care of the mentally ill.

   a. Evaluation of fulfillment of the goal of the project lies in the future. Without additional data, it can only be inferred that improved teaching in schools of nursing will improve practice. However, since follow-up studies of the graduates of a program can give some indication, it is recommended that such studies be done through requests for performance evaluation from employers of the graduates and for statements from the graduates on their evaluation of their educational program as to its soundness as preparation for their role as a beginning practitioner.

   b. In regard to whether or not improved teaching of psychiatric-mental health nursing leads to increased recruitment to the field of psychiatric nursing, it is recommended that a comparative study of the graduates of the participating programs be done to determine any increase in the numbers of those who sought employment in institutions caring for the mentally ill or who went on for further education with the goal of obtaining graduate preparation in psychiatric nursing and that the findings be disseminated nationally.

APPENDIX A. QUESTIONNAIRE AND ATTACHMENT SENT TO PRELIMINARY SAMPLE OF SCHOOLS (NOVEMBER, 1964)

PRELIMINARY QUESTIONNAIRE

Please complete the following questionnaire in as much detail as possible. Fill in the blanks or make check marks in the boxes to the right of each question. Please enclose a copy of your school catalogue with this questionnaire. A stamped envelope is provided for your convenience.

1. What is the length of the total program at this time?.... ______ months

2. What structural change(s) are you able to predict will occur within the next five years? (E.g., shortening the length of the total program, change in the administrative control, etc.) Please list or discuss. Use additional sheet if necessary.

3. How many budgeted positions did you have from September, 1963 to September, 1964?.............................. _____ positions

   a. How many were filled?.............................. ________________

   b. How many resigned?................................. ________________

4. Where are the following courses offered? (Place the appropriate letter in the column marked Location; e.g., a: in parent school; b: in a senior college or university; c: in a junior or community college; d: other (specify).) Also, include number of credits allotted if any.

Subject	Location	No. of Credits
a. Psychology		
b. Sociology		
c. Communications		
d. Growth and development		
e. Other (specify)__________		

5. What is the approximate geographical distance in miles of the cooperating agencies from the parent school/department?

	Miles
a. Psychiatric..	
b. Obstetric..	
c. Public health agency...	
d. Pediatrics...	
e. Other (specify) ____	

6. Under which type of control is the cooperating agency that is utilized for the psychiatric nursing experience?

a. Psychiatric unit in a general hospital ☐

b. Veterans Administration hospital ☐

c. State hospital ☐

d. Community mental health center ☐

e. Other (specify) ________________________________ ☐

7. Which services are offered by the psychiatric agency(s) used by your school/department?

a. Inpatient service ☐

b. Outpatient services ☐

c. Partial hospitalization (e.g., day care, night care, etc.) ☐

d. Community service (e.g., consultation by staff to courts, recreational agencies, welfare depts., etc.) ☐

e. Diagnostic services ☐

f. Rehabilitative services (e.g., vocational, educational, and social programs) ☐

g. Precare and aftercare services (e.g., home visits, foster home placement, halfway houses, etc.) ☐

h. Training of all types of psychiatric and mental health personnel ☐

i. Research ☐

j. Other (specify) ☐

8. How many schools/departments other than your own utilize the same cooperating agency for psychiatric nursing? _______ schools

9. How long was the course in psychiatric nursing during the last year? _______ weeks

10. If you predict a change in the length of time of the course in psychiatric nursing within the next four years, please describe..from ____weeks to ____

11. Who is responsible for the teaching and/or supervision of students in psychiatric nursing in the cooperating agency?

	Teaching	Supervision
a. Instructor from parent school/department	☐	☐
b. Instructor from cooperating agency	☐	☐

12. What is the educational preparation of the psychiatric nursing faculty? (Indicate total number for each highest earned degree.)

	full time	part time
Bachelors	______	______
Masters	______	______
Doctorate	______	______
Other (specify) ______________	______	______
Total number of faculty	______	______

If selected, is your school interested in participating in this project with its stipulated expectations and involvements? .... Yes ☐ No ☐

Name and title of the person completing the questionnaire

____

Name and address of the school/department ______________________

____

Please return the questionnaire by January 1, 1965.

ATTACHMENT TO QUESTIONNAIRE

Expectations for and Involvement of Schools and Departments Participating in the Project

1. The chief administrative officer of the school/department and cooperating agency is willing to give official authorization to the project staff to work with faculty and students and to utilize facilities that would be involved in the project according to its design.

2. The total faculty in the school/department, including faculty in the cooperating agency, is willing to participate in the project, since it is aimed at total curriculum.

3. The school/department and the cooperating agency will permit the project staff to visit the faculty in a consultant capacity when appropriate during the project.

4. The instructors from the schools/departments and cooperating agency will be available for a workshop experience prior to utilization of the guidelines and resource materials developed by the project. (Support is available for participants for maintenance and travel from project funds.)

5. The schools/departments will be interested in a follow-up study of their graduates following completion of the program.

Proposed Plan for School Participation

1. Preliminary questionnaire to determine interest in and suitability for the project.

2. Questionnaire to obtain curriculum data and follow-up visit to the school by the project staff.

3. Faculty participation in a workshop prior to their use of project materials. (Support for participants from project funds.)

4. Use of project guides and materials.

5. Ongoing consultation to faculty members throughout the project by the project staff, focused on content and learning experience in psychiatric-mental health nursing.

6. Follow-up evaluation of the project guides and materials and utilization of evaluation tools as necessary throughout the project.

APPENDIX B. QUESTIONNAIRES SENT TO PARTICIPATING PROGRAMS (MARCH, 1965)

[Editor's Note. The questionnaire sent to the participating diploma programs differed in certain respects from that sent to the associate degree programs. However, in the interest of saving space, the two questionnaires are combined here. Questions addressed to diploma programs only or to associate degree programs only are so indicated. All other questions were included in both questionnaires.]

Directions

Place a check in the space next to the phrase, word, or number that answers the question, or fill in the appropriate phrase, word, or number to complete the statement as it applies to your school/department as of March 1, 1965. Schools/departments will not be identified in any of the materials or reports prepared in connection with the project.

Name of the school ______

Location: City ______ State ______

Date of completion of questionnaire ______

Name of person completing the questionnaire ______

Title ______

OVER-ALL PROGRAM

Students

1. What is your current enrollment of students as of March 1, 1965?

   a. 1st year ______
   b. 2d year ______
   c. 3d year (diploma programs) ______
   d. Total ______

2. Where are the graduates of the class of 1964 currently employed? (Indicate number per category.)

   a. In a general hospital:

      (1) medical unit ______
      (2) surgical unit ______
      (3) obstetrics ______
      (4) pediatrics ______
      (5) psychiatric unit ______
      (6) outpatient dept. ______
      (7) operating room ______
      (8) other (specify) ______
      ______

   b. In a special hospital or an agency:

      (1) psychiatric hospital ______
      (2) maternity hospital ______
      (3) pediatric hospital ______
      (4) nursing home ______
      (5) other (specify) ______
      ______

   c. In a physician's office ______

   d. In private practice ______

   e. In the military services (diploma programs) ______

   f. Engaged in full-time study in a baccalaureate program in nursing ______

   g. Neither employed nor engaged in full-time study ______

h. Do not know ________

i. Other (specify) ________

3. Please indicate the number of graduates of the last four years who are currently employed in psychiatric nursing.

a. 1963 _______ c. 1961 _________
b. 1962 _______ d. 1960 _________

Faculty (diploma programs)

4. Fill in the spaces provided with numbers appropriate to the items in the left-hand columns and indicate by full- or part-time employment, as: 1 F.T., 2 P.T., etc.

Number of Faculty Members by Highest Earned Educational Credential

	Diploma	Associate Degree	Baccalaureate Degree	Masters Degree	Doctoral Degree	Total
Administrative Personnel						
a. Director of school						
b. Assistant director						
c. Guidance director						
Instructors in Clinical Courses						
d. Fundamentals of nursing						
e. Medical-surgical nursing						
f. Maternity nursing						
g. Nursing of children						
h. Psychiatric nursing						
i. Other (specify)						
Instructors in Nonnursing Courses						
j. Psychology						
k. Sociology						
l. Biological sciences						
m. Physical sciences						
n. English						

o. Nutrition ____________________

p. Other (specify) ____________________

Faculty (associate degree programs)

4. Fill in the spaces provided with numbers appropriate to the items in the left-hand columns and indicate by full- or part-time employment, as: 1 F.T., 2 P.T., etc.

Number of Faculty Members by Highest Earned Educational Credential

	Baccalaureate Degree	Masters Degree	Doctoral Degree	Total
Administrative Personnel				
a. Head of department				
b. Assistant				
Instructors in Clinical Courses				
c. Fundamentals of nursing				
d. Nursing in physical illness				
e. Nursing of mothers and children				
f. Nursing in mental illness				
g. Other (specify)				
Instructors in Non-nursing Courses				
h. Psychology				
i. Sociology				
j. Biological sciences				
k. Physical sciences				
l. English				
m. Nutrition				
n. Other (specify)				

5. Is there an ongoing inservice education program specifically designed for instructional personnel of the school? (diploma programs) . . . of the department? (associate degree programs) ....Yes _____ No _____

Curriculum

6. What are the philosophy and objectives of your school? (diploma programs) What are the philosophy and objectives of your nursing program? (associate degree programs)
(Attach copy if you prefer.)

7. (diploma programs)
What are the curriculum and/or level objectives of your school?
(Attach copy if you prefer.)

7. (associate degree programs)
Has your department formulated expected competencies for students at the completion of:

	Yes	No
first year?	_____	_____
second year?	_____	_____

If answer is yes, please attach copy.

8. Are mental health aspects included as part of the curriculum objectives? (diploma programs) . . . as part of the objectives of the department? (associate degree programs) Yes _____ No_____

If answer is yes, please list objectives that indicate these aspects.

9. (diploma programs)
How is the term curriculum defined by your faculty?
(Attach copy if you prefer.)

9. (associate degree programs)
Please describe the over-all program design (curriculum), including courses and credit hours allotted for each.
(Attach copy if you prefer.)

10. (diploma programs)
What is your faculty's definition of a course in clinical nursing?
(Attach copy if you prefer.)

10. (associate degree programs)
What is the ratio for credit allowance for the clinical nursing laboratory courses? .... 1 credit:_____hours of class

11. (diploma programs)
Please describe the over-all program design (curriculum).
(Attach copy if you prefer.)

12. Who is responsible for the development and revision of the (nursing) curriculum?

(diploma programs)
a. Curriculum committee _____
b. Total faculty _____
c. Other (specify) __________
____

(associate degree programs)
a. College curriculum committee _____
b. Department curriculum committee _____
c. Total nursing faculty _____
d. Other (specify) _____
____

13. If there is a (department) curriculum committee, instructors from which of the following areas are full-time members?

(diploma programs)
a. Biophysical sciences _____
b. Psychosocial sciences _____
c. Fundamentals of nursing _____
d. Medical-surgical nursing _____
e. Maternity nursing _____
f. Nursing of children _____
g. Psychiatric nursing _____
h. Other (specify) _____
____

(associate degree programs)
a. Fundamentals of nursing _____
b. Nursing in physical illness _____
c. Nursing of mothers and children _____
e. Biophysical sciences _____
f. Psychosocial sciences _____
g. Other (specify) _____
____

14. What is the length of the total program at this time (March 1, 1965) excluding vacations?

(diploma programs) _____ weeks
(associate degree programs) _____ semesters

15. (diploma programs)
Where are the following courses offered? (Place the appropriate letter in the column marked Location; e.g., a: in parent school; b: in a senior college or university; c: in a junior or community college; d: other (specify).) Also, include number of credits allotted if any and clock hours.

Subject	Location	No. of Credits	Class Hours
a. Psychology			
b. Sociology			
c. English			
d. Growth and development			

16. (diploma programs)
Are psychology and sociology planned as courses for nursing? .... Yes _____ No _____

If the answer is yes, does the home school faculty plan these courses jointly with the instructors? ..... Yes _____ No _____

17. What is the number of clock hours of planned instruction in the following courses?

	Class-room	Conferences	Clinical experience (laboratory)	Total
(diploma programs)				
a. Fundamentals of nursing.........	______	______	______	______
b. Medical-surgical nursing........	______	______	______	______
c. Nursing of children	______	______	______	______
d. Maternity nursing	______	______	______	______
e. Psychiatric nursing	______	______	______	______
f. Other clinical nursing (specify)	______	______	______	______
______________________	______	______	______	______
(associate degree programs)				
a. Fundamentals of nursing	______	______	______	______
b. Nursing in physical illness	______	______	______	______
c. Nursing in mental illness	______	______	______	______
d. Nursing of mothers and children.	______	______	______	______
e. Other clinical nursing (specify)				
______________________	______	______	______	______

18. (diploma programs)
How many weeks of experience are provided in the following clinical areas?

	Weeks
a. Psychiatric nursing	______
b. Nursing of children	______
c. Maternity nursing	______
d. Medical-surgical nursing	______
e. Other (specify)______________________________	______

19. (diploma programs)
By whom is the course in nursing of children planned?

a. Total faculty ______
b. Curriculum committee ______
c. Only the instructor from the parent school ______
d. Faculty of the cooperating agency ______
e. Faculty of the cooperating agency and instructors from the parent school ______
f. Other (specify) ______

20. (diploma programs)
By whom is the course in nursing of children taught?

a. Instructor from home school ____________
b. Instructor in the cooperating agency ____________

21. Check which of the following items are included in the course in nursing of children (diploma programs) in nursing of mothers and children (associate degree programs).

a. The child as a family member ______
b. Mother-child relationships ______
c. Well-child behavior in nursery school ______
d. Behavior of sick child ______
e. Play therapy ______
f. Experience in well-child clinics ______
g. Experience in school health ______

h. Field trips to social agencies (e.g., child welfare) ______

i. Field trips to special schools (e.g., for the mentally retarded) ______

22. In what course is the content related to normal growth and development taught as part of the course content?

(diploma programs)

a. Fundamentals of nursing ______
b. Maternity nursing ______
c. Nursing of children ______
d. Psychiatric nursing ______
e. Psychology ______
f. Sociology ______
g. A separate course ______
h. Other (specify) ______
____

(associate degree programs)

a. Fundamentals of nursing ______
b. Nursing of mothers and children ______
c. Nursing in mental illness ______
d. Psychology ______
______
e. Sociology ______
f. A separate course ______
g. Other (specify) ______
____

23. (diploma programs)
Does the course in growth and development extend through senescence? .... Yes ____ No____

If not, in which course is this content presented?..... ______________

24. (associate degree)
Does the content in growth and development extend through senescence? ....Yes ____ No____
Please explain.

25. (diploma programs)
Who assumes the responsibility of assignment of students' supervision and evaluation of students in the clinical experience in the course in nursing of children? (Check all that apply.)

	Assignment	Clinical Supervision	Evaluation
a. Instructor from parent school			
b. Instructor from cooperating agency			
c. Instructor and head nurse			
d. Head nurse			
e. Other (specify) ______________			

Integration of Mental Health Concepts Throughout the Curriculum

26. In which courses is the following content taught? (Please indicate by course title.)

a. Mental retardation ______________________________
b. Interviewing techniques ______________________________
c. Anxiety and the defense mechanisms ______________________
d. Group process ______________________________
e. Personality development ______________________________
f. Problem solving ______________________________

g. Interdisciplinary team relationships ______________________
h. Patient care plans ______________________
i. Understanding patients' behavior ______________________
j. Supportive nurse-patient relationships ______________________

27. How are students prepared for the psychiatric nursing experience?

28. How are knowledges and skills gained from the course in psychiatric nursing reinforced in the remainder of the students' program of studies?

29. Has your faculty identified mental health content taught in other (clinical) courses in the curriculum? .... Yes ______ No______
Please explain.

30. (diploma programs)
Does your school employ an instructor in psychiatric nursing whose major focus is on integration of mental health concepts throughout the curriculum? .... Yes ______ No______

31. Is there an ongoing plan for integration of mental health concepts throughout the curriculum? .... Yes ______ No______
If the answer is yes, by whom is it planned?

a. Curriculum committee ______
b. Total faculty ______
c. Instructor in psychiatric nursing ______
d. Integrator (diploma only) ______
e. Instructors in the clinical courses ______
f. Other (specify) ______
____

32. (associate degree)
Does the instructor who assumes major responsibility for the content in psychiatric nursing serve as a resource person in the integration of mental health concepts? .... Yes ______ No______

If she serves in other capacities, please explain.

Evaluation

33. What are the tools and techniques used in the evaluation of the total program? (Check all that apply.)

a. Attrition rate ______
b. Follow-up study of the performance of graduates ______
c. Review of state board results ______
d. NLN achievement test scores ______
e. Questionnaires to graduates ______
f. Other (specify) ______
____

34. On what basis is the performance of individual students evaluated for the clinical nursing courses? (Check all that apply.)

a. Grades on teacher-made tests ______
b. Scores on standardized achievement tests ______
c. Performance evaluation ratings by instructor ______
d. Performance evaluation ratings by nursing service personnel (diploma only) ______
e. Other (specify) ______
____

35. Are the following National League for Nursing achievement tests given in your school/department upon the students' completion of their courses? (Check all that apply.)

a. Basic medical-surgical nursing ______
b. Communicable disease nursing ______
c. Obstetric nursing ______
d. Nursing of children ______
e. Psychiatric nursing ______

Guidance

36. What are the philosophy and objectives of the counseling and guidance program? (diploma programs) of the college? (associate degree programs) (Attach copy if you prefer.)

37. (diploma programs)
Which of the following persons are used for referrals?

a. Psychologist ______
b. Psychiatrist ______
c. Religious advisor ______
d. School physician ______
e. Other (specify) ______
____

38. (diploma programs)
Do cooperating agencies provide counseling service to students?
Yes ______ No______
If the answer is yes, please describe.

PSYCHIATRIC NURSING

This section applies to the psychiatric nursing course only (to the course in psychiatric nursing and/or the course in which psychiatric nursing content is taught). Place a check in the space next to the phrase, term, or number that answers the question, or fill in the appropriate number, word, or phrase to complete the statement as it applies to your course in psychiatric nursing at the present time.

1. State board regulations for the course in psychiatric nursing determine which of the following?

a. Number of class hours ______
b. Number of days and weeks of clinical experience (clinical laboratory practice) ______
c. Number of credits
d. Approval of clinical agencies ______
e. Other (specify) ______
____

2. (associate degree programs)
Psychiatric nursing is:

a. Offered as a separate course ______
b. Integrated with ______________
c. Other (specify) ______
____

3. The course in psychiatric nursing (for the typical student) is offered in the:

a. 1st year, 1st semester ______
b. 1st year, 2d semester ______

c. Summer session ______
d. 2d year, 1st semester ______
e. 2d year, 2d semester ______
f. Summer session ______

(diploma programs)
g. 3d year, 1st semester ______
h. 3d year, 2d semester ______
i. Summer session ______

4. How long was the entire course in psychiatric nursing for the typical student during the last year? .... Hours ______
or
Weeks ______

5. Please indicate the approximate number of hours in each category (for an average week).

a. Orientation (diploma only) ______
b. Class ______
c. Conference ______
d. Clinical experience (laboratory) ______
e. Other (specify) ______
____

6. (associate degree programs)
The number of points or semester hours of credit given for the psychiatric nursing course is........................ ______

7. (diploma programs)
Is a fee paid for the psychiatric nursing course and experience? .... Yes______ No ______
If the answer is yes, does the fee include:

a. Tuition ______
b. Room and board ______
c. Library fees ______
d. Health services ______
e. Other (specify) ______
____

If the answer is yes, is the charge made to the students or to the home school? .... Students ______
Home school ______

8. Which of the following courses or subject areas are used as a prerequisite or foundation for the course or course content in psychiatric nursing?

General Education (both programs)
a. Growth and development ______
b. Psychology ______
c. Sociology ______
d. Other (specify) ______
____

Nursing Courses (diploma programs)
a. Fundamentals of nursing ______
b. Medical-surgical nursing ______
c. Maternity nursing ______
d. Nursing of children ______
(associate degree programs)
a. Fundamentals of nursing ______
b. Nursing in physical illness ______
c. Nursing of mothers and children ______

9. The typical faculty-student ratio in psychiatric nursing is:

a. In the class: one to ______
b. In the clinical laboratory: one to ______
c. In a conference: one to ______

10. (diploma programs)
Persons other than the psychiatric nursing instructors who lecture, give conferences, or otherwise regularly participate in the psychiatric nursing course are: (Please indicate number of lecture or conference hours given for each.)

a. Psychiatrist ______
b. Psychologist ______
c. Social worker ______
d. Head nurse ______
e. Occupational therapist ______
f. Recreational therapist ______
g. Clergy ______
h. Other (specify) ______

11. Has your faculty identified specific competencies or expected knowledges, understandings, skills, and attitudes in psychiatric nursing for the student on completion of the course?

a. Yes ______
b. In process ______
c. No ______

12. (associate degree programs)
What is the major focus of the course in psychiatric nursing?

13. Who formulates the objectives for the course in psychiatric nursing? (Check all that apply.)

(diploma programs)

a. Instructors from co-operating agency ______
b. Instructors from the parent school ______
c. Joint planning between parent school and co-operating agency ______
d. Total nursing faculty ______
e. Curriculum committee ______
f. Other (specify) ______

(associate degree programs)

a. Instructors in psychiatric nursing ______
b. Total nursing faculty ______
c. Department curriculum committee ______
d. Other (specify) ______
____

14. Is the psychiatric nursing course organized and developed around any of the following approaches? (If more than one, place in rank order of use by number. Use 1 for the approach used most often, 2 for the next most often, etc.)

a. Problem solving ______
b. Patients' behavior patterns and nursing intervention ______
c. Diagnostic classification ______
d. Principles of psychiatric nursing ______
e. Nurse-patient relationships ______
f. Nursing procedures and treatments ______
g. Case study ______
h. Other (specify) ______
____

15. Which of the following methods are utilized in teaching psychiatric nursing? (Place in rank order of use by number. Use 1 for most-often used, 2 for next most used, etc.)

a. Lecture ______
b. Lecture-discussion ______
c. Group discussion ______
d. Demonstration ______
e. Observation ______
f. Process recordings ______
g. Role playing ______
h. Films ______
i. Case study and presentation ______

j. Field trips ______
k. Nursing care plans ______
l. Instructor-student conferences ______
m. Other (specify) ______
____

16. Which of the following are included as part of the course content in psychiatric nursing? (Check all that apply.)

a. Mental illness as a community problem .... ______
b. Agencies concerned with prevention of mental illness and promotion of mental health .... ______
c. Activities of the public health nurse related to promotion of mental health .... ______
d. Case finding and referral of psychiatric patients .... ______
e. Follow-up of released psychiatric patients .... ______

17. (associate degree programs)
Is one agency used for the clinical experience in psychiatric nursing? .... ______
More than one .... ______
If more than one, please list agencies by types.

18. Students have clinical (laboratory) experiences in which of the following units of the hospital? (Check all that apply.)
a. Admission unit ______
b. Acute treatment unit ______
c. Continued care unit ______
d. Rehabilitation or convalescent unit ______
e. Other (specify) ______
____

19. (diploma programs)
Do students rotate to different units during their experience? .... Yes ______ No ______
If so, to how many different units?..... ______

20. (diploma programs)
How many weeks of evening and night experiences are planned? .... ______ evening ______ night

21. Are additional experiences offered for students in any of the following settings? (Check all that apply.)

a. Outpatient clinic ______
b. Child guidance clinic ______
c. Alcoholic clinic ______
d. Day hospital ______
e. Night hospital ______
f. Emergency services ______
g. Rehabilitation agencies:
  (1) Vocational ______
  (2) Educational ______
  (3) Social ______
h. Halfway houses ______
i. Home visits ______
j. Schools for the mentally retarded ______
k. Other (specify) ______
____

22. Place a "P" in the space next to those of the following treatments in which the student participates and an "O" next to those she observes.

Psychotherapy

a. Individual with psychotherapist ______

Adjunctive Therapy

a. Occupational therapy ______

b. Group ______
c. Milieu ______

Somatic Therapies

a. Electro-convulsive ______
b. Insulin ______
c. Hydrotherapy ______

b. Recreational therapy ______
c. Music therapy ______
d. Psychodrama ______
e. Dance therapy ______
f. Other (specify) ______
____

23. What is the major textbook used by the students in the course in psychiatric nursing? ____________________

Cooperating Agency or Psychiatric Units in the Home Hospital (diploma programs)
Clinical Resources Used for Psychiatric Nursing Laboratory (associate degree programs)

If psychiatric units in the home hospital (diploma programs). . . in general hospitals (associate degree programs) are used, some of the following questions will not apply.

Name of cooperating agency ____________________

Location of the cooperating agency: City __________ State __________

24. What is the approximate geographical distance in miles of the cooperating agency from the home school/college?........... ______ miles

25. How many programs other than your own utilize the same cooperating agency for psychiatric nursing? .... ______ programs

26. On what basis was the cooperating agency selected?

27. What other disciplines utilize the psychiatric hospital or unit for education and experience? (Check all that apply.)

a. Occupational therapy ______
b. Social work ______
c. Psychology ______
d. Psychiatry ______

e. Recreational therapy ______
f. Chaplains ______
g. Other (specify) ______
____

28. Which of the following does your contract with the cooperating agency include? (Check all that apply.)

a. Nature and extent of the responsibility assumed by the home school/college .... ______
b. Nature and extent of the responsibility assumed by the cooperating agency .... ______
c. Provision of facilities .... ______
d. Responsibility for teaching of students .... ______
e. (diploma programs) Responsibility for student supervision.. ______
f. (diploma programs) Amount of experience to be provided for students .... ______
g. (associate degree programs) Length of time students will be in the hospital .... ______
h. Financial agreement .... ______
i. Other (specify) . ____________________

29. By which of the following organization(s) is the cooperating agency/home hospital accredited?

   a. Council on Medical Education of the American Medical Association ______
   b. Joint Commission on Accreditation of Hospitals .... ______
   c. State accrediting group .... ______
   d. Other (specify) ________________________ ______
   e. None .... ______

30. Are the patients' records available for student use? Yes ____ No ____

31. What are the philosophy and objectives of the nursing service department in the psychiatric hospital or unit? (Attach copy if you prefer.)

32. How does the nursing service department in the psychiatric hospital or unit evaluate their nursing care?

33. (diploma programs)
    Do the instructors in the psychiatric hospital or unit hold dual positions? .... Yes ____ No ____

34. Is there an ongoing inservice education program for all levels of the nursing staff in the psychiatric hospital or unit?.. Yes ____ No ____
    If the answer is yes, please describe.

35. The bed capacity of the unit where students have their most extended learning experience is:

   a. Under 25 ______
   b. 26-50 ______
   c. 51-100 ______
   d. Over 100 ______

36. What is the professional nurse-patient ratio on this unit? one to ______

37. What is the distribution of nursing personnel for a typical 24-hour period on units utilized by students?

	Percent of Nursing Care			
	Day	Evening	Night	Total
a. General duty	_____	_______	_____	_____
b. Nonprofessional	_____	_______	_____	_____
c. Total hours	_____	_______	_____	_____

38. Where are individual and small-group conferences with students held?

   a. On the unit ______
   b. In the instructor's office ______
   c. Other (specify) ______
   ____

39. Assignments (learning experiences) in the clinical areas provide opportunity for the student to give care through which of the following means? (Check all that apply.)

   a. Team nursing ______
   b. Groups of patients ______
   c. Individual patients ______
   d. Functional assignment ______
   e. Other (specify) ______
   ____

40. Are nursing care plans prepared for all patients? ..... Yes ____ No ____
If the answer is yes, by whom are they developed? ____________________

41. (associate degree programs)
Are pre- and post-conferences used in the clinical laboratory experience? .... Yes ____ No ____

42. In the laboratory facility, is there a separate nursing library ____ or a combined medical-nursing library ______?

43. Please fill in the following blanks.

a. Number of different titles of psychiatric nursing texts in the library published after 1960 .... ______
b. Number of different nursing journals in the library....... ______
c. Number of different medical journals pertaining to psychiatry in the library .... ______
d. Do you consider that the space for study in the library is adequate? .... Yes ____ No ____
e. Is the library open during the evenings? .... Yes ____ No ____
f. Is the library open on weekends? .... Yes ____ No ____
g. Is there a separate budget item for nursing texts and journals in the laboratory facility? .... Yes ____ No ____

EVALUATION

44. Which of the following methods are used in evaluating the student's achievement? (Check all that apply.)

a. Teacher-made tests ______
b. Student self-evaluation ______
c. Diaries ______
d. Performance ratings by instructor ______
e. Student-faculty individual conferences ______
f. NLN achievement tests ______
g. Performance ratings by nursing service personnel ______
h. Other (specify) ______
____

45. (diploma programs)
Who participates in the evaluation of the students' total learning experiences?

a. Psychiatric nursing instructors .... ______
b. Students .... ______
c. Nursing service personnel .... ______
d. Other (specify) ____ ______

46. Indicate the state board performance in psychiatric nursing of the last three classes to graduate:

Year:	1962	1963	1964
State mean	____	____	____
School mean	____	____	____
Number of failures	____	____	____

47. What do you consider to be the major strengths of your course in psychiatric nursing?

48. Please describe any problems you have found in your course in psychiatric nursing.

49. Please describe how you expect your school/department to benefit from participation in this project.

APPENDIX C. QUESTIONS DISCUSSED WITH CONSULTANTS FROM ASSOCIATE DEGREE AND DIPLOMA PROGRAMS

INTEGRATION

1. How do you see integration of psychiatric-mental health nursing concepts throughout the clinical nursing courses in relation to the philosophy of associate degree or diploma nursing education?

   a. Do you see this content as psychiatric and mental health nursing content or as a part of general nursing content?
   b. Do you see this content as focusing on the prevention of mental illness or on the promotion of mental health in patients?
   c. How would you describe the content that is integrated or is an integral part of the other clinical nursing courses?

EXPECTED COMPETENCIES

2. What behaviors do you expect of students at the end of the program as a result of integration of psychiatric-mental health content? (In knowledges, skills, abilities, appreciations, and attitudes.)

   a. How would you break these down into steps in student learning?
   b. What, if any, would be the critical incidents?
   c. What broad areas of content do you see as being necessary to the student's achievement of these competencies?
   d. How do you plan for the inclusion of this content in the clinical courses? (By segments, by degrees of achievement, by steps.)
   e. How do you show this content in your course outlines?
   f. What methods do you use to teach this aspect of general nursing care?

3. What is your evaluation of your experiences with integration?

   a. Describe your successes, your failures or weaknesses.
   b. What areas need to be strengthened?

PSYCHOSOCIAL SCIENCES

4. Do you see this content as proceeding from the normal to the abnormal, or do you think the course in psychiatric nursing should be used as a basis for interpersonal skills and knowledges?

   a. Do you see content from general psychology and general sociology as a basis for content for integration in the clinical courses?
   b. As a basis for the course in psychiatric nursing?
   c. How is this content utilized or reinforced in the course in psychiatric nursing and/or for integration?
   d. Is integrated content used as a basis for psychiatric nursing?
   e. Is content on growth and development used as a basis for psychiatric nursing?

f. What is the relation between this content and mental health content?
g. Where in the curriculum is growth and development taught?
h. (diploma programs) Do you think students should take their courses in psychology and sociology in a college or university?

PSYCHIATRIC NURSING COURSE

5. In terms of the philosophy of associate degree or diploma nursing education, do you believe these programs prepare the graduate for beginning positions in psychiatric nursing?

   a. What competencies are achieved as a result of the course in psychiatric nursing?
   b. Are they different in kind from some competencies resulting from other clinical courses?
   c. What would be the critical incidents?
   d. What should be the focus of the course in psychiatric nursing?

6. (associate degree programs)
   Should there be a separate course (block) in psychiatric nursing, or should it be completely integrated with nursing in physical and mental illness? If the latter, how would you do this?

7. (associate degree programs)
   Is the course in psychiatric nursing taught in the same manner as the other clinical courses?

   a. Pre- and post-conferences.
   b. Use of problem solving.
   c. Nursing care plans.
   d. If process recordings are used, how are they utilized and how do they differ from nursing care plans?

8. Is it possible to show concurrency of content and learning experiences on the outline for this course? If so, how?

9. Do you believe students need a special introduction to the clinical laboratory in psychiatric nursing?

10. How do you stress communication with other disciplines in psychiatric nursing?

11. Do you believe the psychiatric nursing course should be the same as other courses in regard to familiarization with community agencies? What are your reasons?

12. Is the same student-faculty ratio maintained as for other clinical courses?

13. Are any courses or content areas prerequisite to the course in psychiatric nursing?

14. (diploma programs)
    Do you believe schools should supply their own instructor for the course in psychiatric nursing?

15. On what bases should the cooperative agency be selected?

16. As in other clinical courses, should the use of physician lecturers be limited?

SPECIFIC CONTENT

17. Where do you begin teaching communication skills?

    a. What is the emphasis on in this content?
    b. Do you teach interviewing as a part of communication skills?
    c. Are these skills built on in the psychiatric nursing course?

18. Where do you think discussing patient behavior should begin? Is this built on in psychiatric nursing?

19. When do you think concern with the student's awareness of her own behavior should begin?

20. Do you believe students in these programs should have some knowledges, skills, et cetera, relative to groups of patients and working with groups of patients?

21. What content on nursing care of the mentally retarded should be included at this level?

22. Do you believe personality factors in patients with organic disorders, alcoholism, drug addition, psychosomatic disorders, psychoneurotic illnesses, or suicidal tendencies could be taught in nursing in physical illness or medical-surgical nursing?

23. Do you believe students in these programs should have some knowledge about psychiatric illness in children? What would be the limits on this content?

APPENDIX D. QUESTIONS ON PROJECT DEFINITIONS AND EXPECTED COMPETENCIES SENT TO PARTICIPATING PROGRAMS

DIRECTIONS

Enclosed are questions about the expected competencies and some of the definitions developed within the project. We request that the total faculty respond to these questions. Two copies are enclosed: one may be retained for your files. Please return one completed copy to our office by May 19, 1967. Use the backs of pages if necessary.

As we are planning to publish the project definitions and expected competencies in a form that can be used as guidelines by diploma and associate degree nursing programs, we are asking your faculty to review them. The reactions of your faculty to these materials are very important to us. Please read and respond to each section on the definitions before answering the questions on the expected competencies.

EXPLANATION

Definitions

The definitions were developed by the project staff. They have been reviewed and edited by the Advisory Committee to the project, the Steering Committee of NLN's Council on Psychiatric and Mental Health Nursing, and a consultant group of experts in psychiatric nursing representing different settings for psychiatric care and levels of education for psychiatric nursing, as well as the staff of NLN's Department of Diploma Programs and Department of Associate Degree Programs.

The definitions were used by the staff and consultant group of experts in psychiatric nursing as one means of providing direction to the development of the project expected competencies in the area of psychiatric-mental health nursing for students in diploma and associate degree nursing education programs.

Expected Competencies

The expected competencies were developed by the project staff after a meeting with a consultant group of instructors representing the different clinical areas from diploma programs in nursing and a meeting with a similar group from associate degree nursing programs. The competencies were revised by the group of experts in psychiatric nursing and reviewed by the Advisory Committee, the Council Steering Committee, and the two NLN departments.

Within the project, consideration has been given to present-day trends in psychiatric nursing and the influence of present-day trends in general nursing on psychiatric nursing. The trends and influences considered were: two levels of nursing practice as delineated in the ANA position paper on nursing; the integration of psychiatric-mental health nursing concepts throughout the curriculums of basic programs; the role of the nurse in the community-centered approach to the problem of mental illness; the therapeutic community as a treatment modality in psychiatric hospitals; working with groups of patients as well as individual patients; and working with the nursing and interdisciplinary teams. These trends were of central importance during the development of the project definitions and expected competencies.

In November of 1966, the project definitions and expected competencies were sent to the individuals who had attended the project workshop as representatives of the programs participating in the project. They were to be used as resource materials by faculty in the participating programs as they developed and refined competencies expected of students in their programs.

QUESTIONS

I. Definitions.

You may find it helpful to read the definitions of nursing and technical occupation before answering these questions.

A. Are the definitions of each of the following terms applicable to your program in the light of the philosophy of your department or school? If not, please explain.

1. Beginning first-level practitioner in nursing.
2. Beginning first-level practitioner in nursing care of the mentally ill.

II. Expected Competencies.

A. General Practice of Nursing (terminal behaviors).

This is a list of minimal over-all competencies to be achieved by students immediately prior to completion of associate degree or diploma programs in nursing. The definition of beginning first-level practitioner in nursing was used for direction for these competencies. Please limit your comments to the competencies listed.

1. Are the competencies listed under general practice of nursing consistent with what your faculty believes should be expected of a student completing an associate degree or diploma program in nursing? Please explain your point of view.
2. Are these expectations too limited for this type of program? Please explain your point of view.
3. Are these expectations too great for this type of program? Please explain your point of view.
4. Please write any other comments you may have about these particular competencies.
5. Do the competencies provide direction for evaluation of students? If so, please indicate an example of one that does and state how it would lead to evaluation of students in your program.
6. If the competencies do not provide direction for evaluation, please explain why.

I. Definitions.

You may find it helpful to read the definitions of psychiatric nursing and therapeutic use of self before answering these questions. According to the project definitions, the nurse working in a psychiatric setting interacts with many patients, develops a relationship with a few patients, and intervenes with all patients as required.

A. Are the definitions of each of the following terms applicable to your program in the light of the philosophy of your department or school? If not, please explain.

1. Nurse-patient interaction.
2. Nursing intervention.
3. Nurse-patient relationship.

II. Expected Competencies.

A. Nurse-Patient Relationship.

These competencies are based on the definition of the nurse-patient relationship. However, they are to be considered from the standpoint of a nurse-patient relationship with any patient in any clinical area and as part of the over-all nursing care plan, although the learning experience in depth may most frequently take place in the course or unit in nursing care of the mentally ill. Many of these competencies also apply to nurse-patient interactions and nursing interventions.

1. Are the competencies listed under the nurse-patient relationship consistent with what your faculty believes should be expected of a student completing an associate degree or diploma program in nursing? Please explain your point of view.
2. Are these expectations too limited for this type of program? Please explain your point of view.
3. Are these expectations too great for this type of program? Please explain your point of view.
4. Please write any other comments you may have about these particular competencies.
5. Are there any additional competencies you would add under this category? If so, please list them.
6. Do the competencies provide direction for evaluation of students? If so, please indicate an example of one that does and state how it would lead to evaluation of students in your program. If not, why?
7. Do you see any of the individual competencies as being critical in terms of passing or failing a student? If so, please list which one(s).

B. Communication Skills.

The competencies relative to communication skills are part of the nurse-patient relationship. Because of their importance, they have been listed separately so that they could be considered in more detail. Many of these competencies also apply to nurse-patient interactions and nursing interventions. You may find it helpful to refer to the definition of the word communication prior to answering these questions.

1. Are the competencies listed under communication skills consistent with what your faculty believes should be expected of a student completing an associate degree or diploma program in nursing? Please explain your point of view.
2. Are these expectations too limited for this type of program? Please explain your point of view.
3. Are these expectations too great for this type of program? Please explain your point of view.
4. Please write any other comments you may have about these particular competencies.
5. Are there any additional competencies you would add under this category? If so, please list them.
6. Do the competencies provide direction for evaluation of students? If so, please indicate an example of one that does and state how it would lead to evaluation of students in your program. If not, please explain.

7. Do you see any of the individual competencies as being critical in terms of passing or failing a student? If so, please list which one(s).

C. Working with Others. (Nursing team, interdisciplinary team, small groups of patients.)

Reference has been made to the nurse working with others in previous definitions and to the expected competencies for the general practice of nursing. Competencies listed under each of these headings are abilities required for working with any group. "Small groups of patients" refers to patient groups in any clinical area, even though most of the learning experiences resulting in these competencies may take place in the course or unit in nursing care of the mentally ill.

1. Are the competencies listed under working with others consistent with what your faculty believes should be expected of a student completing an associate degree or diploma program in nursing? Please explain your point of view.
2. Are these expectations too limited for this type of program? Please explain your point of view.
3. Are these expectations too great for this type of program? Please explain your point of view.
4. Please write any other comments you may have about these particular competencies.
5. Are there any additional competencies you would add under this category? If so, please list them.
6. Prior to your participation in the project, did you include the area of working with groups of patients as part of the competencies expected of students in your program? If so, please list them.
7. Are you planning to include the area of working with groups of patients in the competencies expected of your students, as a result of your participation in the project? Please explain.

D. Therapeutic Environment.

Please read the definitions of the terms milieu therapy, therapeutic ward environment, and therapeutic community. Reference has been made to the nurse and the therapeutic environment in previous definitions and to the expected competencies for the general practice of nursing.

1. Please write any comments you may have on the competencies listed under this heading.

E. Community.

Reference has been made to the consideration of community aspects by the nurse in the expected competencies for the general practice of nursing. These competencies apply specifically to the course or unit in nursing care of the mentally ill.

1. Please write any comments you may have on the competencies listed under this heading.

General Questions

I. Definitions.

A. Did your faculty use the project definitions as they worked on their expected competencies and content organization as part of their participation in the project? If so, in what way did they use them? If they were not useful, please explain.

B. Was the definition of psychiatric-mental health nursing content helpful to your faculty as they worked on their expected competencies and content organization as part of their participation in the project? Please explain your response.

C. Please write any comments you wish to make on any of the other project definitions.

D. Please list any additional words or phrases that you think need to be defined for the project.

II. Expected Competencies.

A. Did your faculty find the project competencies useful as guides in developing competencies for your own curriculum? If so, how? If not, how were they not useful?

B. Were you able to use any of the individual project competencies or sections of the project competencies directly as you developed competencies for your own curriculum as part of your participation in the project? If so, please list those that were used.

C. Do you plan to use any of the individual project competencies or sections of project competencies directly as objectives for your curriculum? If so, please list.

APPENDIX E. TERMINAL EXPECTED COMPETENCIES

TERMINAL EXPECTED COMPETENCIES RELATED TO THE GENERAL PRACTICE OF NURSING

I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.

II. The student gives safe, effective nursing care to one or a group of patients with major health problems, under the supervision of a nurse with broad professional preparation.

  A. Develops an individualized nursing care plan based on patient needs and nursing problems, using the problem-solving approach.
    1. Identifies patient needs and nursing problems.
    2. Hypothesizes about the reasons for patient needs and nursing problems.
    3. Identifies appropriate nursing care and states the reasons for its appropriateness; *e.g.*, the nurse-patient relationship.
    4. Cooperates with and contributes to the nursing team as a team member in planning for nursing care.
    5. Cooperates with members of other disciplines and contributes to the planning for total patient care as she plans for nursing care.
    6. Evaluates her own knowledges, skills, abilities, attitudes, and appreciations as they may influence her nursing care.

  B. Implements her plan for nursing care.
    1. Adjusts her plan on a priority basis, taking into consideration both direct and indirect influences on patient needs and nursing problems.
    2. Recognizes her limitations and seeks appropriate assistance.
    3. Cooperates in coordinating nursing care of assigned patients with the care given by other health workers.

  C. Evaluates her plan for nursing care.
    1. Identifies changes in patient needs and nursing problems.
    2. Determines the effectiveness of nursing care in terms of the nursing care plan and the total treatment plan.
    3. Validates her findings with other health workers.

  D. Revises her plan for nursing care on the basis of the evaluation.
    1. Supplements knowledges and develops skills as needed.
    2. Seeks appropriate assistance.

III. The student relays pertinent information accurately and appropriately.

  A. Differentiates between events and inferences.
  B. Describes patient needs and nursing care given.
  C. Reports crucial information immediately.
  D. Writes a pertinent account of her observations and her nursing care.

TERMINAL EXPECTED COMPETENCIES RELATED TO THE NURSE-PATIENT RELATIONSHIP

I. The student has an appreciation of herself both as a person with varying physical, psychological, and developmental needs and as a practitioner with responsibilities, potentialities, and limitations.

II. The student engages in a supportive relationship, as the need dictates, with a selected patient, under the supervision of a nurse with broad professional preparation.

- *A. Plans for the supportive relationship based on patient needs and nursing problems, using the problem-solving approach.
    1. Initiates contact with the patient.
    2. Assesses the patient's present and potential capabilities and goals, taking into consideration his limitations, both physical and emotional.
    3. Avoids labeling the patient.
    4. Writes a plan for the supportive relationship that is a part of the over-all nursing care plan.
    5. Plans the supportive relationship so that it is part of the total treatment plan for the patient.
- B. Implements her plan for the supportive relationship.
    1. Establishes the supportive relationship.
        - a. Orients the patient to the functions and purposes of the relationship, setting limits on the relationship.
        - b. Begins consideration of plans with the patient for conclusion of the relationship.
        - c. Identifies roles she assumes in the relationship.
    2. Continues the supportive relationship.
        - a. Recognizes when the relationship is in the continuing phase.
        - b. Recognizes her limitations and seeks appropriate assistance.
        - c. Recognizes that her feelings about the patient influence her behavior toward him, which in turn influences his behavior.
        - d. Identifies and accepts as not personally significant the patient's positive and negative verbalizations and behaviors.
        - e. Exhibits positive attitudes toward the patient; _e.g._, she is:
            - (1) Nonpunitive.
            - (2) Nonjudgmental.
            - (3) Accepting.
            - (4) Permissive.
            - (5) Empathic.
        - f. Promotes the relationship through nursing actions based on the patient's needs; _e.g._,
            - (1) Carries out individualized safety measures.
            - (2) Sets realistic limits for the patient.
            - (3) Stays with or leaves the patient when this action would benefit him.
            - (4) Is consistent in her behavior and attitudes.
            - (5) Utilizes communication skills knowledgeably.
                - (a) Is aware of the relationship between her communication and the response of others.
                - (b) Is aware of the effect of her anxiety on her ability to communicate purposefully.
                - (c) Attends to the communication of others.
                - (d) Observes nonverbal communications.
                - (e) Recognizes prominent themes in the communication of others.
                - (f) Tolerates silence.

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*All that follows is an artificial separation of a process that is closely interwoven and overlapping but has been outlined to make student evaluation more feasible.

- (g) Keeps open the flow of effective verbal communication.
- (h) Validates the communications of others with them.
- (i) Is purposeful in her communication.
- (j) Is selective in her verbal response.
- (k) Limits her communication to discussion of the current situation.
- (l) Respects the principles of confidentiality.

g. Recognizes the implications of signs of change in patient behavior; e.g.:
  - (1) Level of anxiety.
  - (2) Level of depression.
  - (3) Level of withdrawal.
  - (4) Level of hostility.

h. Accepts the patient's progressive independence.
i. Continually revises her plan for the relationship as needed (see item C below).
j. Discusses those feelings about the patient that affect her nursing care with a nurse with broad professional preparation.

3. Concludes the supportive relationship.
  - a. Follows through on plans previously made with the patient for conclusion of the relationship.
  - b. Identifies and accepts her feelings of separation anxiety.
  - c. Identifies and accepts the patient's feelings of separation anxiety as evidenced by his behavior.

C. Evaluates her plan for the supportive relationship.

1. Identifies changes in patient needs and nursing problems on the basis of changes in the patient's behavior.
2. Determines the effectiveness of the relationship in terms of the goals of the relationship.
3. Accepts the patient's present and potential capabilities and goals, taking into consideration his limitations, both physical and emotional.
4. Recognizes and accepts her limitations in the relationship.

D. Revises her plan for the relationship on the basis of the evaluation.

1. Supplements knowledges and skills as needed.
2. Seeks appropriate assistance.

TERMINAL EXPECTED COMPETENCIES RELATED TO WORKING WITH GROUPS

I. The student functions in group situations with patients, with the nursing team as a team member and also functions as such on the interdisciplinary team.

A. Is aware of her strengths and limitations and seeks appropriate assistance.
B. Is aware of the possible effects of her own behavior on others in the group.
C. Identifies her role as a nurse in the group.
D. Maintains and interprets her role in the group.
E. Assumes other appropriate group roles in the group.
F. Contributes to the group by supplying information from her frame of reference.

G. Considers the group needs in planning, initiating, and following through on group discussions and activities.
H. Utilizes unstructured group situations to engage the group in activity or discussion toward planned ends.
I. Cooperates with and contributes to the total functioning of the group.
J. Communicates purposefully in her interactions in the group.
K. Appreciates the possible effects of each group member on others in the group.
L. Identifies constructive and destructive group interaction.
M. Supports constructive interaction among group members.
N. Intervenes in destructive group interaction directly or by seeking appropriate assistance.
O. Discusses her feelings about the group with the group and/or with a nurse with broad professional preparation.

TERMINAL EXPECTED COMPETENCIES RELATED TO THE THERAPEUTIC ENVIRONMENT

I. The student contributes to the establishment and maintenance of a therapeutic environment.

A. Considers in her nursing care plan the effect of the immediate environment on the patient.
B. Is aware that health workers have an influence on the environment.
C. Identifies disruptive and therapeutic factors in the environment.
D. Initiates modifications in the immediate environment of assigned patients when needed and when possible.
E. Carries out safety measures.

APPENDIX F. OPERATIONAL DEFINITIONS

The definitions given below are an attempt to bring together in one place the precise meanings of the technical terms as used in this project. The definitions are derived from recognized authorities in education and nursing. Where these are quoted verbatim or are paraphrased closely, references are cited in the usual way. In other cases, we have freely paraphrased the words of several authorities but are still able to cite chapter and page of particular works. Frequently, however, a definition combines elements from a number of different sources, elements so interwoven that definite attribution can no longer be made. In such cases, our references become bibliographic lists rather than citations. In all other cases, the dictionary consulted in formulating the definitions was Webster's New Collegiate Dictionary, Springfield, Mass., G. & C. Merriam Company, 1960. In definitions of general educational terms, masculine personal pronouns are used; in definitions of nursing terms, feminine pronouns are used for the nurse and masculine for the patient. An asterisk before a term indicates that the definition has been revised since its appearance in the Workshop Report.

Ability: The student's concurrent utilization of knowledge and skill in a situation different from the one in which learning took place.[1] Frequently manifested by the student's capacity to solve, interpret, apply, work, do, et cetera.[2] See also Knowledge, Skill.

Appreciation: The full awareness, recognition, and just estimation of a thing's worth and scope. See also Attitude, Value.

Attitude: A persistent disposition primarily grounded in emotion and expressive of opinions rather than beliefs. Implies action that is either positive or negative, that varies in intensity, and that is directed toward a person, a group, an object, a situation, or a value system.[3] Frequently manifested by what the student enjoys or does not enjoy, chooses to do or not to do, et cetera.[4] See also Appreciation, Value.

*Beginning First-Level Practitioner: For the purposes of this study, the term first-level practitioner designates a nurse who administers direct nursing care; i.e., performs intermediate nursing functions[5] requiring skill and some judgment, in the presence or at the bedside of the patient who is under the care of a physician.[6] She is a contributing member of the nursing team and works under the supervision of a nurse with broad professional preparation.[7] She assumes some responsibility for the direction and supervision of those ancillary personnel who are members of the same team.

A beginning first-level practitioner is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience in nursing after graduation.

See also Nursing, Technical Occupation.

*Beginning First-Level Practitioner in Nursing Care of the Mentally Ill: For the purposes of this study, the term first-level practitioner in nursing care of the mentally ill designates a nurse who administers direct supportive nursing care to the mentally ill patient on a one-to-one or small-group basis. Direct supportive nursing care is rendered in the daily living situation in which the nurse and patient find themselves and is consistent with the over-all treatment goal for the patient determined by the interdisciplinary team. The nurse focuses on strengthening the patient's areas of health and deals only with those thoughts and feelings that the patient brings up and with his behavior. Her nursing care is purposeful and planned, and although it may take many forms, it is based on her knowledges, skills, abilities, attitudes, and appreciations about the behavioral manifestations of the major forms of mental illness. Her primary therapeutic tool in her interactions with patients is "use of self."

In all her activities, the first-level practitioner in nursing care of the mentally ill functions under the supervision of a nurse with broad professional preparation in nursing or a professional psychiatric nurse. She is a contributing member of the nursing team and also functions as such on the interdisciplinary team as it establishes and implements total treatment plans for the patient.

A beginning first-level practitioner in nursing care of the mentally ill is a technical nurse who has graduated from a state-approved diploma school or associate degree program of nursing, is eligible for licensure or is currently licensed in the state in which she practices, and has had less than one year's work experience after graduation in nursing care of the mentally ill.

See also Ability, Appreciation, Attitude, Knowledge, Psychiatric Nursing, Skill, Supportive Nursing Care, Technical Occupation, Therapeutic Use of Self.

Behavior: Mode of conducting oneself; the way in which a person acts in response to a stimulus. See also Entering Behavior, Expected Competencies, Level of Achievement, Terminal Expected Competency.

Communication: All the modes of behavior that one individual employs consciously or unconsciously to affect another--not only the spoken and the written word but also gestures, body movements, somatic signals, and symbolism in the arts. "Non-verbal communication, as a matter of fact, is considered to be a more reliable expression of true feelings than verbal, because the individual has less conscious control over his non-verbal behavior."[8]

Functions of human communication serve the purpose of mediating information across the boundary lines of the human organism or the group organization. Specifically, they solve the problem of how events outside an organism or an organization are represented in terms of information on the inside and how events on the inside are relayed to the outside. The functions of communication include:

1. Perception (the reception of incoming signals).
2. Evaluation (which involves memory and the retention of past experiences as well as decision-making).
3. Transmission and expression of information.

People communicate by making statements. These statements are signals that are coded in various prearranged ways. When they impinge upon earlier impressions, they become signs. These signs, in the strictest sense of the word, exist only in the minds of people, because their interpretation is based upon prior agreements. A statement becomes a message when it has been perceived and interpreted by another person. Finally, when sender and receiver can consensually validate an interpretation, then communication has been successful.[9]

Concept: A class of a number of objectives, events, things, and behaviors that differ in appearance. A mental image of a thing formed by generalization from particulars. *E.g.*: chair, house, round, tall. Concept achievement is observed when the student becomes capable of responding to different objects (events and behaviors) as if he were placing them in one or more classes (classifying them into one or more categories).[10] *See also* Principle, Problem-Solving, Theory.

Content: Matter that is dealt with by, or presented in, a field of study. This matter is specifically stated and is derived from the objectives of the learning experience. Not to be confused with *Concept* (which see). *See also* Descriptive Approach, Dynamic Approach.

Critical Incident: A technique for evaluating clinical performance. Critical incidents are those behaviors that have been found to make the difference between success and failure in carrying out an important part of a specific assignment. Such incidents are crucial in the sense that they have been responsible for outstandingly effective or definitely unsatisfactory performance of an important part of the job or activity in question.[11]

The crucial elements of a job or activity (critical incidents) are determined by experts in the field. Inherent in the determination of a critical incident is that it occurs frequently. When the critical incident is used as an evaluation device, every student must have the opportunity to engage in the act under question. However, only those students at the extremes of performance will be differentiated by this technique. Evaluation of student performance by means of the critical incident technique must be done by experts in the field.

See also Evaluation, Incident.

Descriptive Approach: Recounts, characterizes, or classifies the material of a field of study. *See also* Content, Dynamic Approach.

Dynamic Approach: The interaction of forces that results in change. For the purposes of this study, emphasis will be placed on environmental, intrapersonal, and interpersonal forces. Consideration is given to the identification and explanation of the forces underlying behavior, situations, et cetera.[12] *See also* Content, Descriptive Approach.

Entering Behavior: Certain knowledges and skills manifested in behavior that are prerequisite to a new sequence of instruction and learning.[13] *See also* Behavior, Expected Competencies, Level of Achievement, Terminal Expected Competency.

Evaluation: A process for determining to what extent the learning experiences as developed and organized are actually producing the desired results. Implied in the term are: (1) an appraisal of the entering behavior of the student, since it is change in this behavior that is sought in education; (2) more than a single appraisal at any one time, since in order to see whether change has taken place, it is necessary to make an appraisal at an early point and other appraisals at later points to identify changes that may be occurring.[14] *See also* Behavior, Entering Behavior, Expected Competency, Level of Achievement, Terminal Expected Competency.

Expected Competencies:[15] A description of the desired outcome(s) of a program of studies, a course, or any given learning experience. They are stated in behavioral terms that describe what the learner is to be like as a result of the learning experience. They indicate the minimal acceptable level of achievement and are derived from and consistent with the philosophy of the program. See also Behavior, Entering Behavior, Level of Achievement, Terminal Expected Competency.

External Environment: The aggregate of all the conditions and influences, animate and inanimate, tangible and intangible, outside the living organism that affect its life and development. See also Internal Environment.

Incident: Any observable type of human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing this act.[16] See also Evaluation, Critical Incident.

*Integration: "The process of forming new, larger, and more comprehensive whole responses by which differentiated objects and activities are apprehended. It is the combining of details which emerge from larger wholes and ultimately acquire such a degree of individuality and specificity that they are united with other particulars and are reorganized into a coherent pattern."[17] For the purposes of this study, the learning experiences provided by the instructor will be such that content from psychology and sociology as well as psychiatric-mental health nursing content will be interwoven throughout the clinical courses in the nursing curriculum. While learning experiences that facilitate integration of content are provided by the instructor, the process of integration takes place within the student. See also Content, Learning Experience, Psychiatric-Mental Health Nursing Content.

Interaction: Mutual or reciprocal action or influence that produces an effect, especially a change in the condition of something.

Internal Environment: The aggregate of all the conditions and influences within the living organism that affect its life and development. See also External Environment.

Interpersonal Relationship:[18] An interaction (which see) between the individual and his external environment (which see) that is influenced by previous experiences with other persons and objects in the external environment. Although it is recognized that the individual reacts to inanimate objects in the physical setting, for the purposes of this study, emphasis will be placed on the individual's interaction with one or more persons in his social milieu. The individuals involved in an interpersonal relationship interact as participants and as observers, each assuming an active part in a particular situation by observing the response of the other and reacting on the basis of this observation. See also Intrapersonal Relationship, Relationship.

Intrapersonal Relationship:[19] Phenomena, experiences, or interactions occurring within the individual and ultimately affecting his behavior. This behavior is determined in part by the individual's past experience with intrapersonal relationships. Intrapersonal relationships are continuous and therefore occur during all interpersonal relationships, thereby affecting and being affected by them. For the purposes of this study, the term intrapersonal relationship shall be used interchangeably with the terms intrapersonal interaction and and intrapersonal experience. See also Interaction, Interpersonal Relationship, Relationship.

Knowledge: An idea or a phenomenon to which a student has been exposed and which he can remember either by recall or recognition.[20] Frequently manifested by the student's capacity to name, describe, list, state, explain, et cetera.[21] See also Ability, Skill.

Learning: The acquisition of knowledges, skills, and abilities (which see) that results in a change in behavior in the learner. Has the characteristics of being unitary, individual and social in context, self-active, purposive, creative, and transferable.[22] See also Learning Experience.

Learning Experience: The interaction between the learner and the external conditions in the environment to which he can react. These conditions are purposefully planned so as to stimulate the desired reaction in the learner.[23] See also Interaction, Learning, Teaching.

*Level of Achievement: A position or rank in a progression of steps derived from the objectives of the learning experience and resulting in a terminal expected competency. A student's level of achievement is manifested in his behavior. See also Behavior, Entering Behavior, Expected Competencies, Terminal Expected Competency.

Mental Health: A state of being resulting from a personality that is organized in a manner that:

1. Is acceptable to the individual.
2. Results in optimum growth and development, or self-actualization.
3. Enables the person to function autonomously.
4. Enables the person to perceive reality with minimal distortion.
5. Enables the person to achieve mastery over his environment.
6. Enables the person to have positive affective relationships.

This personality organization is manifested by, and inferred from, patterns of behavior. Mental health has no absolute inherent value. Therefore, when concerned with evaluating the degree of mental health achieved by a person, consideration must be given to standards set by the culture in which he lives and his total personality structure. The above criteria are interdependent and are guides rather than rules for the assessment of the degree of mental health manifested by an individual.[24]

See also Mental Illness.

Mental Illness:[25] A state of being of a living human organism manifested by, and inferred from, his patterns of behavior. Behavior considered to be indicative of mental illness is determined in part by the individual's total personality organization and the values held by the culture to which the individual belongs. Therefore, "mental illness" is not an absolute concept, but a state that varies from individual to individual and from culture to culture. It is also not absolute in the sense that no person is totally mentally ill, but rather manifests behavior indicative of varying degrees of health and illness.

Generally, then, mental illness is a behavioral manifestation of the degree to which the individual's reaction to himself and his interaction with others and the environment are inadequate and/or inappropriate in light of his own total personality organization and the culture to which he belongs.

Specifically, in the United States mental illness has been classified by the Committee on Nomenclature and Statistics of the American Psychiatric Association for the use of physicians in whose province lies the responsibility for diagnosing illness.

See also Mental Health, Psychiatry.

Method: An orderly procedure or process; a manner of doing anything. For the purposes of this study, the word method will refer to the manner of instruction and evaluation; for example, lecture, small-group discussion, use of audio-visual aids, critical incident technique, et cetera. See also Evaluation, Teaching.

Milieu Therapy: A nonspecific phrase referring to treatment by means of modifying the environment in a hospital setting.[26] See also Therapeutic Community, Therapeutic Environment.

Nurse-Patient Interaction:[27] The purposeful, planned behavior of the nurse that has an effect or influence on the patient and that, in turn, is affected or influenced by the patient's response. Therefore, the nurse-patient interaction is a dynamic two-way process. The behaviors of the nurse and the patient combine to bring about mutual, although not necessarily similar, changes in the thoughts, feelings, and behaviors of the two persons. See also Nurse-Patient Relationship, Nursing Intervention.

Nurse-Patient Relationship:[28] An interaction process necessarily involving the nurse and the patient in fairly prolonged contact over a period of time. The nurse offers a series of purposeful activities and practices based on a body of theoretical and empirical knowledge, with the goal of fostering the patient's physical, social, and emotional well-being. This relationship differs from a social relationship, in which two persons interact primarily for reasons of pleasure or companionship, with neither person in a position of responsibility for helping the other.

The nurse-patient relationship takes place in the daily living situation in which the nurse and the patient find themselves and is consistent with the over-all treatment goal for the patient determined by the interdisciplinary team. It is not an end in itself, but rather a means through which (1) other aspects of nursing care are facilitated and can be made more effective and (2) the patient experiences a meaningful, healthy, satisfying interpersonal relationship, to the end that he may be able to transfer that which he has learned from this relationship to his relationships with others.

The goals of the nurse in a nurse-patient relationship are based on the needs of the patient and are designed to provide opportunities that will help the patient to grow emotionally. They include helping the patient to (1) maintain himself biologically; (2) identify, state, and meet his specific and concrete needs whenever possible; (3) clarify his feelings; (4) participate with others; (5) communicate with others; (6) increase his self-esteem; (7) increase his comfort and minimize his anxiety; and (8) test reality.

The nurse helps the patient to achieve these goals through the use of both verbal and nonverbal communication and by employing the following purposeful and planned attitudes and activities based on her knowledges and abilities: acceptance, respect, sensitivity, support, reassurance, encouragement, empathy, understanding, limit-setting, and consistency. The nurse deals only with conscious material and does not make dynamic interpretations of meaning to the patient. She focuses on strengthening areas of health. Emphasis is placed on current problems of the patient's living with others in the ward setting. The manner in which and the degree to which these attitudes and practices are implemented and manifested are determined to a great extent by the nurse's own unique personality and the degree of her self-understanding, self-acceptance, and educational preparation.

The nurse-patient relationship is artificially divided into three phases of development. In reality, these phases cannot be isolated, but tend to overlap.

The first phase is initiating the relationship. This phase is centered upon mutual attempts to know each other and to help the patient become oriented to his environment. The commencement of this phase is the responsibility and the function of the nurse, although in some instances the patient may take the initiative. Establishment of the foundations of acceptance and mutual trust is the predominant feature of this phase.

The second phase is continuing the relationship. The focus of this phase is on helping the patient to benefit from the interaction through the use of the attitudes, the activities, and the practices stated above.

The third phase is concluding or terminating the relationship. This phase is concerned with helping the patient to transfer his healthy modes of interaction from the nurse to others in his social milieu, both within and outside the hospital.

The nurse is supervised in this relationship, preferably by an experienced nurse with professional preparation.

See also Interaction, Interpersonal Relationship, Nurse-Patient Interaction, Nursing Intervention, Process Recording.

Nursing: One of the health occupations, which provides service to the individual, the family, and the community in health and in illness. The occupation of nursing includes several levels of practitioners: professional, technical, and vocational.[29] In addition, there is a group of semiskilled workers who assist the nurse in her practice.

Nursing as an occupation is an art and a science that requires the application of knowledge and the principles of biological, physical, and social sciences in the prevention of illness and in the treatment and rehabilitation of individuals in need of health services.[30]

The distinctive feature of nursing practice is the responsibility for doing for (or along with) a person, in whole or in part, that which he and/or his family ordinarily would do but are unable to do for a time or at all times.[31] This practice is directed toward identifying and meeting in varying degrees the physical, social, emotional, and spiritual needs of the individual, to the end that he is enabled to achieve or resume his position in society, function within the limitations imposed by his illness, or conclude his life-span as comfortably as possible.

There are seven areas of nursing function, the first six of which are independent:[32]

1. The supervision of a patient involving the whole management of [nursing] care, requiring the application of principles based upon the biologic, the physical, and the social sciences.
2. The observation of symptoms and reactions, including symptomatology of physical and mental conditions and needs, requiring evaluation or application of principles based upon the biologic, the physical and the social sciences.
3. The accurate recording and reporting of facts, including evaluation of the whole care of the patient.
4. The supervision of [nursing personnel and the coordination of] others, except physicians, contributing to the care of the patient.

5. The application and the execution of nursing procedures and techniques.
6. The direction and the education to secure physical and mental care.

The one dependent area of nursing function is:[33]

7. The application and the execution of legal orders of physicians concerning the treatments and medications, with an understanding of cause and effect thereof.

In addition to the broad legal nursing functions outlined above, nursing also includes the following more specific functions:[34]

1. Ministering to the basic human needs.
2. Teaching self-care or counseling on health.
3. Participating in the patient's restorative activities in modification of daily living.
4. Planning with the patient for self-care, which is an outgrowth of managing the care for him--determining and timing the course of action and controlling the manner of its performance.
5. Communicating and interacting with the patient throughout all nursing functions--to give the patient opportunities to develop a sense of trust and a feeling of significance and ultimately of self-realization.

Nursing Care Plan:[35] A written evaluation of the patient's individualized nursing care needs, along with suggestions as to how these needs may best be met. Developing a nursing care plan is essentially a problem-solving process and requires that the nurse have ability to:

1. Identify the needs of the patient, including priorities of need.
2. Understand the possible reasons for the existence of these needs.
3. Identify appropriate nursing care, including priorities of care.
4. Understand how and why this nursing care may meet the patient's needs.

The nursing care plan is designed to guide the nurse in giving effective nursing care and is therefore developed prior to the administration of the care. However, the nursing care given on the basis of the initial nursing care plan is evaluated, and the plan is then revised accordingly. In fact, planning nursing care is an ongoing process subject to evaluation and revision as the needs of the patient change, as more information is gathered, and as greater depth of understanding of the patient is attained. Evaluation of the nursing care plan (reporting and describing the nursing care given and the patient's responses) forms the essence of the nurse's notes.

Contributions to the nursing care plan are made by all nursing personnel concerned with the care of the patient, taking into consideration the total plan of care developed by the interdisciplinary team. The use of the nursing care plan by all nursing personnel facilitates communication and continuity of patient care.

Although the nurse and the nursing team may increase their knowledge about a specific patient and their skill in rendering nursing care through the use of a nursing care plan, a nursing care plan is not essentially a teaching tool, but rather, a device designed to help in the provision of consistently effective nursing care to patients. Therefore, it is appropriately used in all instances in which a patient is in need of nursing care services.

See also Problem-Solving.

Nursing Intervention: The purposeful, individualized, planned activity of the nurse designed to help the patient regain psychophysiological homeostasis in a specific crisis situation associated with his illness. This crisis situation is a result of a psychophysiological disequilibrium caused by either internal or external forces with which the patient cannot cope unaided.

In psychiatric nursing, nursing intervention--the purposeful, individualized, planned activity of the nurse--is designed to help the patient deal with an increase in anxiety engendered by a specific crisis situation associated with his illness. This crisis situation can be a result of either increased intrapsychic conflicts or environmental forces with which the patient cannot cope unaided.

See also Nurse-Patient Interaction, Nurse-Patient Relationship.

Nursing Problem: A condition presented by the patient reflecting a situation faced by him or his family with which the nurse can assist him or them through the performance of nursing functions and activities.[36] Nursing problems need to be differentiated from the problems of the nurse and the patient's medical diagnosis. Although all three are closely related, only a statement of the nursing problem provides direction for determination of nursing functions and activities.

For example: The basic nursing problem of Patient A is:
To promote the development of productive interpersonal relationships.

Patient A's specific problem is:
Patient consistently remains by himself in a corner of the dayroom.

In contrast, the nurse's problem is:
Patient A does not agree to join the nurse and other patients in a group activity, and his medical diagnosis is schizophrenia.

See also Nursing Care Plan, Problem-Solving, Process Recording.

Philosophy: The beliefs through which man tries to understand himself and the world in which he lives. In relation to education, these beliefs underlie and provide the rationale for the goals of the educational process and for the methods used in the attainment of these goals.[37]

Principle: A specific statement of a theory involving a chain of concepts of the form "If A, then B." Serves to establish connection between different phenomena.[38]

See also Concept, Problem-Solving, Theory.

Problem-Solving: A kind of learning by means of which principles are put together in chains to form "higher order principles." These become the generalizations that enable the student to think about an ever-broadening set of new problems. Requires the prelearning of concepts and principles, and is manifested by the student's ability to propose and evaluate a solution to a new problem.[39]

See also Concept, Principle.

Process Recording: An exact written account of the verbal and nonverbal interaction between the nurse and the patient during a specified period of time. It includes an objective account of what the patient said and did and what the nurse said and did. This is followed by an analysis of what the nurse believes to have been the meaning of the interaction, including her feelings and those that she thinks the patient may have experienced.

It is helpful if the process recording is written in columns, as this format facilitates appreciation of both the vertical and the horizontal association of aspects of the interaction. In addition, sufficient space should be allowed for the instructor to write comments.

It is mandatory that a process recording be not only reviewed by the instructor but also discussed with the student on an individual basis in conference.

A process recording is written as soon after the interaction as possible in order to minimize the margin of error. It is rarely written during the interaction. This is not to say that the fact that process recordings are being kept should be hidden from the patient, but rather, that the nurse should be free from all distractions during the interaction. The patient needs to be assured both verbally and by her manner that the nurse will abide by the principles of confidentiality.

A well-done process recording is very valuable in helping the nurse to identify themes in both her behavior and that of the patient. Also, it helps the nurse to evaluate the progress of the nurse-patient relationship and to plan for its continuation. Each process recording can provide one basis upon which the over-all nursing care plan is revised in preparation for the next interaction with the patient.

As a teaching-learning tool, the process recording is useful in learning dynamics of human behavior, interpersonal relations, communication skills, self-awareness, et cetera, and can be useful in any nurse-patient interaction at any point in the curriculum. The use of this tool can commence with the first clinical nursing course but in the form of simple records of the interaction, known as interaction notes.

If the student had experience with interaction notes when studying nurse-patient interactions prior to the course or unit in nursing care of the mentally ill, she should be quite adept at executing the mechanics of the process recording when studying the nurse-patient relationship in the course or unit in nursing care of the mentally ill.

The most extensive use of the process recording will most likely be in the course or unit in nursing care of the mentally ill, since the primary focus of this course or unit is the interaction process. In addition, at this time the student will acquire a greater depth of knowledge about behavior, which will enable her to analyze the interaction more accurately and in greater depth than she had previously been able to do.

Prior to the use of this tool, its purpose should be thoroughly explained to the student and its use should be clearly related to the objectives of the experience. Purposeful or inadvertent censoring of the record by the student cannot, in most instances, be prevented. However, this should not be the cause of undue concern to the instructor, since the recognition by the student of what might have been a more appropriate response or behavior on her part indicates that learning must have taken place. Undue pressure on the student to be "right" at all times can be avoided to some degree if the process recording is not graded.[40]

See also Nurse-Patient Relationship, Nursing Care Plan, Nursing Problem, Problem-Solving.

Psychiatric Nursing: The field of nursing in which the major therapeutic goal of nursing care provided to patients is the promotion of mental health (which see), the prevention and the detection of mental illness (which see), and the treatment and the rehabilitation of patients with psychiatric disorders.

In providing such care, the function of the nurse is not different in nature from nursing in other clinical fields, but it does differ in its primary focus on interpersonal one-to-one and group relationships.[41]

More specific functions of the nurse include:[42]

1. Creating a therapeutic environment (which see)--acceptance, understanding, and provision of opportunities for the patient's emotional growth.
2. Studying the ward social structure in order to promote healthy socialization.
3. Establishing relationships with individual patients.
4. Establishing relationships with groups of patients.
    a. Structured or formal groups (patient government meetings, remotivation, activity groups, et cetera).
    b. Unstructured or informal groups (spontaneous discussions, et cetera).
5. Intervening in crisis situations.

The general goal of psychiatric nursing is to help patients to accept themselves and improve their relationships with other people.[43]

The field of psychiatric nursing includes several levels of practitioners--the professional psychiatric nurse (clinical specialist), the professional nurse, the technical nurse, and the vocational nurse--all of whom work with patients who are mentally ill. In addition, there is a group of semiskilled workers who assist the nurse in her practice.[44] For the purposes of this study, beginning first-level practice in psychiatric nursing shall be referred to as nursing care of the mentally ill, so as to differentiate technical-level practice.

See also Nursing.

*Psychiatric-Mental Health Nursing Content: For purposes of this study, psychiatric-mental health nursing content is considered to be the knowledges that are related to the understanding of individual and group behavior. These knowledges are based on the psychosocial sciences, the biophysical sciences, and psychiatry. When applied in the practice of nursing, these knowledges are manifested in the ability to engage in nurse-patient interactions, nursing interventions, and the nurse-patient relationships (which see), on both an individual and small-group basis. Inextricably involved in all of these abilities are communication and/or interviewing skills, skills in environmental modification, and appropriate attitudes in giving nursing care to all patients; i.e., both the physically ill and the mentally ill. Therefore, psychiatric-mental health nursing content is part of all nursing content. See also Communication, Integration, Therapeutic Environment.

Psychiatry: That specialized body of medical knowledges and skills that is primarily concerned with the study, prevention, diagnosis, and treatment of abnormal behavior in human beings.

Relationship: The state of being mutually or reciprocally interested or influential, thereby being connected.

Skill: A mode of operation and generalized technique for dealing with a problem. Little or no specialized and technical information is required. Although a skill can be learned, its mastery is more dependent upon natural endowment and experience than upon formal education. A skill may also be referred to as an art.[45] See also Ability, Knowledge.

Supportive Nursing Care: For the purposes of this study, supportive nursing care is the behavior of the nurse, based on the process of problem-solving (which see), in which she meets the needs of the patient in a manner that encourages the growth of the healthy aspects of his personality and minimizes the pathological aspects; i.e., she reinforces his current healthy defenses. The primary focus of supportive nursing care is to assist the patient to utilize more fully current effective patterns of behavior, as differentiated from focusing primarily on behavioral manifestations of the patient's psychopathology. See also Beginning First-Level Practitioner in Nursing Care of the Mentally Ill, Nurse-Patient Interaction, Nurse-Patient Relationship, Nursing Intervention.

Teaching: The imparting of knowledges and techniques through a variety of means both directly (example: instruction) and indirectly (example: role model) in any setting in which there is a recipient (learner). Implies not only instruction but also stimulation, encouragement, and guidance of the student by the teacher.[46]

Although the development of abilities, appreciations, and attitudes (which see) may be an indirect result of the teaching process, these cannot be directly taught, since their acquisition is dependent upon the capacity of the student to analyze, integrate, evaluate, and internalize his experiences.

See also Integration, Learning

Technical Occupation: A vocation requiring skillful application of a high degree of specialized knowledge together with a broad understanding of operational procedures; involving the frequent application of personal judgment; usually dealing with a variety of situations; and often requiring the supervision of others. It offers the opportunity for the worker to develop an ever increasing personal control over the application of his knowledge to his work and usually requires fewer motor skills than a trade or a skilled occupation and less generalized knowledge than a profession.[47] See also Beginning First-Level Practitioner.

*Terminal Expected Competency: The description of the desired outcome(s) of a program of studies, a course, or any given learning experience. It is stated in behavioral terms describing the expected performance of the student that has been established as the minimal acceptable level of achievement at the end of a planned unit of instruction and indicating that the learner has achieved the objective(s); i.e., there has been a behavioral change in the student. It is derived from and consistent with the philosophy of the program.[48] The term terminal expected competency is used interchangeably with the term terminal behavior. See also Behavior, Entering Behavior, Expected Competencies, Level of Achievement.

Theory: A statement that explains invariable associations (laws). Cannot be proved by direct perception because it does not state anything that has been or can be observed, but rather, characterizes general patterns or regularities to which individual phenomena conform and by virtue of which their occurrence can be systematically anticipated.[49] See also Concept, Principle, Problem-Solving.

Therapeutic Community: A specialized form of the therapeutic environment (which see). It utilizes all the principles that underlie the latter and others as well.

Among the distinctive features of the therapeutic community are the following:

1. Patients are included in practically all information sharing processes on the ward.
2. Patients' opinions are included in decisions about other patients' readiness for such things as passes and discharges.
3. Such patient inclusion in a democratic community process is considered treatment.[50]

All therapeutic communities have in common emphasis on open communication and group interaction. The main focus of the treatment program in the therapeutic community is on a variety of group meetings in which the process of interaction between staff and patients goes on. Group therapy (formal) is only one part. Other examples are ward meetings and activity groups.

These various group meetings and the therapeutic community as a whole serve to enhance and support other forms of concurrent treatment.

Each person, patient, or staff member serves some therapeutic function. Therefore, the personalities of the patients and staff are very important and help to determine the uniqueness of each individual therapeutic community. In all, however, communication among staff is of prime importance in planning, implementing, and evaluating the therapeutic community and in avoiding serious professional and personal conflicts.

A therapeutic community is a concept of treatment based on the belief that the hospitalization of an individual does not remove him from society, but rather, places him in a different society that is subject to study and regulation. "It may expose the patient to exactly the same pressure and interaction as elsewhere, but more carefully, with better timing and a simultaneous opportunity to gain insight into the nature of his emotions and behavior."[51]

This concept points up the therapeutic value of social relationships, but implementation of this concept varies from therapeutic community to therapeutic community.

See also Milieu Therapy, Therapeutic Environment.

Therapeutic Use of Self:[52] The nurse's employment of her own unique personality in interactions with an individual patient or a group of patients, with the goal of helping to produce a beneficial effect on those involved. The nurse's therapeutic use of self is an integral part of the nurse-patient relationship.

That the effect of this interaction is potentially beneficial is based on the following assumptions:

1. Helping patients to change their behavior as one way of improving their intrapersonal and interpersonal relationships is an appropriate goal of psychiatric nursing.[53]
2. Changes in patient behavior occur as a result of emotional experiences.[54]
3. One way in which a patient has emotional experiences is through interactions with the nurse.
4. These interactions are beneficial only if the nurse manifests an attitude of acceptance toward the patient.[55]
5. The nurse cannot truly accept the patient unless she accepts herself.
6. Since the nurse is a unique individual with a personality that differs from the personality of any other individual, it is necessary for her to continually grow in self-awareness so that she may be self-accepting.

7. Self-awareness and self-acceptance enable the nurse to manifest behavior that is consistent with her thoughts and feelings.
8. Consistency of the nurse's thoughts and feelings with her behavior constitutes a therapeutic asset.[56]

See also Nurse-Patient Interaction, Nursing Intervention, Nurse-Patient Relationship.

Therapeutic Environment: A milieu designed to help patients develop a sense of self-esteem and personal worth, to improve their ability to relate to others, to help them learn to trust others, and to return them to the community better prepared to resume their roles in living and working.[57]

In order to be therapeutic, the patient's environment must be purposeful and planned. Aspects to be taken into consideration are: physical aspects--i.e., homelike colors, furniture, et cetera, and provision for privacy; personal aspects--i.e., provision for physical needs such as food, cleanliness, rest, safety, et cetera, and acceptance in a friendly, warm atmosphere; and social aspects--i.e., provision for interaction and communication among patients and personnel.

A therapeutic environment meets the basic needs of the individual and provides a testing ground for the patient for new patterns of behavior.[58] It is based on a sound basic understanding of psychodynamics by the staff.

A therapeutic environment respects the individuality of each patient and at the same time provides for participation in democratic group activity. Emphasis is placed on socializing activities, for which the patients are encouraged to take increasing responsibility. Free-flowing communication among patients and staff, among patients, and among staff is essential.

A true therapeutic environment cannot be achieved unless an atmosphere of acceptance and optimism prevails throughout the unit. Any serious personal or professional conflict between staff members must be recognized and dealt with.

The setting of limits is not inconsistent with the concept of the accepting, permissive, democratic atmosphere of the therapeutic environment, but rather, is an essential part of it and reflects the realities of living in a democratic society.

The environment can be said to be therapeutic only if the philosophy is consistently implemented over the period of time that the patient is in the hospital. Consequently, it can be seen that the major responsibility for providing a therapeutic environment rests with the nursing personnel, the group of workers who are in the closest continual contact with the patients.

Continual appraisal, evaluation, and modification are mandatory if the therapeutic environment is to be a dynamic living force that helps patients to move in the direction of health.

See also Milieu Therapy, Therapeutic Community.

Understanding: The power to render experience intelligible by bringing perceived particulars under appropriate concepts. Frequently manifested by the student's capacity to adapt and modify knowledge to a new experience. See also Concept.

Value: The internalized worth of a thing, a phenomenon, or a behavior.[59] Enables the individual to make moral judgments, which, in turn, provide the basis for his behavior. See also Appreciation, Attitude.

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APPENDIX H. PROGRESS REPORTS

During the period 1965-1968, progress reports on the project were given at meetings of the groups listed below. Those for which the locations are not given took place at NLN headquarters.

1965

1. Steering Committee of the NLN Council on Psychiatric and Mental Health Nursing.

2. NLN Council on Psychiatric and Mental Health Nursing, NLN Biennial Convention, San Francisco, California.

1966

1. Steering Committee of the NLN Council on Psychiatric and Mental Health Nursing.

2. NLN Council of Member Agencies of the Department of Associate Degree Programs, Annual Meeting, St. Louis, Missouri.

3. Council on Psychiatric and Mental Health Nursing of:
   a. Southeastern Pennsylvania League for Nursing, Philadelphia, Pennsylvania.
   b. New Jersey League for Nursing, Trenton, New Jersey.

1967

1. Steering Committee of:
   a. NLN Council on Psychiatric and Mental Health Nursing.
   b. NLN Council of Member Agencies of the Department of Associate Degree Programs.
   c. NLN Council of Member Agencies of the Department of Diploma Programs.

2. NLN Council of Member Agencies of the Department of Associate Degree Programs, Annual Meeting, San Francisco, California.

3. NLN Biennial Convention, New York, New York.
   a. NLN Council of Member Agencies of the Department of Diploma Programs.
   b. NLN Council of Member Agencies of the Department of Associate Degree Programs.
   c. NLN Council on Psychiatric and Mental Health Nursing.

4. Michigan League for Nursing, Ad Hoc Committee on Psychiatric Nursing Education, Detroit, Michigan.

5. Fourth Annual Seminar on "Teaching in Associate Degree Nursing Programs," Department of Nursing, Purdue University, Lafayette, Indiana.

1968

1. NLN Council of Associate Degree Programs, Annual Meeting, Boston, Massachusetts.

2. Georgia League for Nursing, Council on Psychiatric and Mental Health Nursing, 10th Annual Convention, Augusta, Georgia.

3. University of Pennsylvania School of Nursing, Conference on "Integration of Mental Health Concepts in Diploma Nursing Programs," Philadelphia, Pennsylvania.

In addition, project staff reported on the project to the Advisory Committee of the project titled Teaching Psychiatric Nursing in Diploma Schools, which was sponsored by the Southern Regional Education Board, Mental Health Unit, under a grant from the National Institute of Mental Health, in the course of serving as consultants to the Advisory Committee.